STATE GUIDE TO MEDICAID COST CONTAINMENT

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STATE GUIDE TO MEDICAID COST CONTAINMENT

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Bruce Spitz
September, 1981

INTRODUCTION

The State Guide to Medicaid Cost Containment is an updated and greatly expanded version of an earlier edition published in 1980 and authored by Bruce Spitz, with the assistance of Fred Teitelbaum, Gretchen Engquist-Seidenberg, and Richard Curtis. The Guide is published jointly by the Intergovernmental Health Policy Project and the National Governors' Association as a part of their mission to share information on important state innovations and alternatives as a focus for future discussion, analysis and problem solving.

Like the earlier version, the new Medicaid Guide addresses the divergent information needs of the various state policymakers that play key roles in shaping each State's Medicaid program. For governors who must assume the lead in setting the broad policy parameters of the program; for legislators who are responsible for raising the revenues to support the program and for overseeing its implementation; and for administrators who are charged with improving program management and the delivery of services in an era of shrinking resources, the Medicaid Guide identifies a variety of viable cost containment options which are capable of minimizing harmful effects on recipients and institutions and, at the same time, offer the greatest potential for holding down the rate of growth in program expenditures.

The Medicaid Guide is organized around six broad strategies:

- minimizing or eliminating the use of open-ended provider-controlled reimbursement;
- minimizing the inappropriate use of the program by both recipients and providers;
- redirecting the delivery of services toward more appropriate, less expensive settings;
- minimizing eligibility errors;
- minimizing Medicaid's subsidy of other third parties; and
- maximizing the purchasing power of the State.

It is important for the reader to understand that the cost containment strategies discussed in this publication were developed prior to the adoption of major changes in the Medicaid program by the First Session of the 97th Congress. Whereas some of the strategies discussed by the author previously would have required new legislation or, at least, a federal waiver to implement, action taken by Congress in 1981 has transformed

many heretofore hypothetical strategies into realistic opportunities for the States. For example, States are no longer tied to Medicare reimbursement principles for reimbursing inpatient hospital care. Another significant change gives States greater latitude in determining the nature and scope of eligibility and services for the "medically needy" population. The law also eliminates the mandatory PSRO purview over Medicaid utilization review activities.

Unfortunately, a detailed analysis of the additional cost containment options now available to the States as a result of recent changes in federal law must await a later publication. However, Appendix A does provide the reader with a very brief summary of some of the more significant changes in federal policy effected by the 97th Congress.

Given the recent changes in federal policy with respect to Medicaid and the ongoing escalation in the cost of the program to both the States and the federal government, there is little doubt that Medicaid-related issues will dominate the state health agendas for the next few years.

Growth in total state revenues in most States has been far less than the average annual growth of 14-15 percent in Medicaid expenditures over the past few years. Early in 1981, more than half the States projected moderate to serious shortfalls in their Medicaid budgets. By May of 1981, eleven States still reported sizeable deficits, while thirteen States were forced to approve supplementary appropriations to offset anticipated deficits. The States reported a host of reasons for the shortfalls: 1) national economic circumstances resulting in expanding caseloads and declining state revenues; 2) increased utilization 3) continued high inflation in medical costs; 4) loss of General Revenue Sharing; and 5) state and local tax spending limitations.

Progress toward achieving overall health policy goals in any given State is largely a function of that State's capacity to manage and control the rate of growth in its Medicaid program. An inefficient and inadequately managed Medicaid system drains limited state resources away from other health programs and other state initiatives which may have an even greater impact on overall health status; e.g., nutrition, education, and housing. It is a surprising fact that, in many States, the annual dollar increase alone in the State's Medicaid budget is more than the total amount of dollars devoted to all other health programs, with the possible exception of mental health.

The various cost containment strategies discussed in this guide are limited specifically to the Medicaid program. While it is generally acknowledged that the complex problems in the health care sector cannot be resolved — and indeed may even be aggravated — by focusing exclusively on Medicaid, the ability to experiment with the Medicaid program has provided the foundation for the development of a number of innovative cost containment practices widely supported today; e.g., utilization review, HMOs, prior authorization, preadmission screening and prospective reimbursement. With the expanded discretion States now enjoy over the administration of their programs, and the enhanced opportunities they have to experiment through waivers, it is reasonable to assume that many more innovative and successful cost containment techniques will emerge over the next few years.

While this paper identifies a broad range of cost containment options available to the States, the inclusion of any specific alternative or strategy should not be interpreted as an endorsement by either the Intergovernmental Health Policy Project or the National Governors' Association. It must be stressed that, although general strategies may be widely adaptable throughout the States, specific options are likely to be more limited in applicability. Hence, a particular strategy that has demonstrated results in Nevada, for example, may be completely inappropriate for New Hampshire. Each State, therefore, must carefully evaluate each proposed alternative in the context of its own policies and practices.

Given the enormous changes in Medicaid policy, the issue is no longer what degree of latitude the States should exercise over the management and allocation of Medicaid dollars but, rather, how will the States respond to the new challenges and opportunities before them. It is our hope that the Medicaid Guide will contribute significantly to the decision-making processes at the state level and to an improvement in the overall operation of state Medicaid programs.

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CHAPTER I

A FRAMEWORK FOR MEDICAID COST CONTAINMENT

Medicaid is a joint state-federal program designed to provide health care to the poor. It has become one of the largest, most complex programs administered by the States. Total Medicaid expenditures, including state and federal shares, exceeded $20.5 billion in FY 79.[1] State and local expenditures totalled nearly $9.3 billion in the same year.[2] At an average annual growth rate of 15 percent, total Medicaid expenditures should approximate $23.6 billion in FY 80 and should exceed $27 billion in FY 81.

Medicaid is not only one of the largest programs that States fund, but it also represents the single most rapidly increasing item in most state budgets. For the past few years, Medicaid expenditures have been increasing at a rate much greater than the increase in state revenues. In Michigan, for example, the projected increase in Medicaid expenditures is greater than the total increase expected for all state revenues.[3] While not all States face an identical situation, more than one-half faced moderate to serious financial problems with their Medicaid programs during 1981.[4] These problems are exacerbated during recessionary periods, as the States become caught in a triple bind of rising welfare roles, declining revenues and strong resistance to tax increases. Confronted with these problems, States are forced to either contain Medicaid costs or to make major sacrifices in welfare, education and other public programs. Unfortunately, the need to contain costs often obscures the primary purpose of the program; viz., the provision of essential medical care to a needy population. Under these circumstances, the most visible and immediate means for containing costs are restrictions on eligibility or limitations on benefits. Such cutbacks, however, not only compromise the primary reason for having a Medicaid program but also shift the burden for caring for the needy onto localities and locally subsidized public hospitals, clinics and nursing homes. Benefit reductions can also increase costs because treatment is either provided in a more expensive setting or delayed until the individual's medical condition becomes more critical and thus more costly to address. Before state officials embark on a cost containment program which eliminates coverage for people and services, they should exhaust all the options they have to assure that their Medicaid programs are designed and managed as effectively and efficiently as possible.

Clearly, restrictive and confusing federal regulations often make it difficult for the States to properly administer their Medicaid programs, much less control their costs. Nonetheless, the States can do a great deal to alter policies over which they have discretion and to significantly improve their administrative practices.

In assessing cost containment strategies, it is essential to recognize that state

Medicaid programs vary widely. The savings that can be realized from a specific cost containment strategy will depend on a variety of conditions within a given State. For example, some States provide liberal reimbursement to Medicaid providers, but have restrictive eligibility standards and service coverage policies. In other States, the pattern is reversed.[5] These and other variations in state programs strongly suggest that a given policy change will have different expenditure implications from State to State. Being able to select an appropriate strategy depends on the type and quality of information available to the state's Medicaid agency. Before a cost containment package is designed, the agency should review the cost and utilization experience of the program, compare that information with other programs and compile a detailed inventory of all existing Medicaid limitations, reimbursement constraints and utilization controls.

The description of a Medicaid program should break down costs and utilization rates by client category, provider type and major geographical regions. If possible, costs should be further disaggregated by the eligible population and the recipient population (i.e., those individuals actually receiving services). In addition, the agency should trace the rates of change in cost and utilization across the client/provider categories for the past several years. If possible, the effects of inflation, increases (decreases) in utilization, and the growth (decline) of the number of eligibles on the rates of change in costs should be analyzed. (A similar analysis should be done of the factors which might have affected increases in rates of change in utilization.) Finally, information on other comparable state Medicaid programs should be collected as well as information on non-Medicaid provider/population costs and utilization levels and rates of change for the State or region within which the Medicaid agency operates.

Next, States should assess the reasonableness of their Medicaid utilization and costs. The costs and rates of change can be compared with statewide data related to non-Medicaid patients, to other Medicaid programs within the region, and to other regions within the State. Inconsistencies in the rates of change for the various components of the state's Medicaid agency should also be noted. All unexplained discrepancies are potential targets for cost containment, even those which are on the low side. For example, low physician fees may be directly linked with excessive use of hospital outpatient departments and emergency rooms.

Next, the State should make a detailed inventory of state Medicaid regulatory constraints, noting how long they have been in effect, and compare those constraints with federal requirements. This inventory provides a very rough indication of where and how client controls, reimbursement and utilization review mechanisms might be tightened. For example, it would not be fruitful to focus a great deal of energy on welfare fraud as a source of savings if the standards for eligibility are stringent, the eligibility process is carefully monitored, error rates are low and there is a highly active and effective client investigation unit. While purging the system of its last welfare cheater is always politically appealing, the State would receive a greater return in exploring ways to control costs by changing its reimbursement practices or strengthening its utilization controls.

Once the State has completed this descriptive aspect of its analysis, it should rank potential areas of cost containment by provider type, client category and if possible, services. The ranking should be based on the absolute size of expenditure category, projected trends, and the potential for imposing further regulatory constraints. As a matter of practice, the Medicaid agency should start with the most costly expenditure items (e.g., hospitals or nursing homes) and work down because a small percentage reduction in a major expenditure will frequently exceed savings that can be realized on small items.

Estimates of savings must take into account the administrative costs needed to implement the change. In addition, substitution effects that might result from clamping down on one type of provider or service (e.g., substitution of other provider types, use of other state programs or reliance on county or city supported services) must be acknowledged.

Indeed, if clients were to substitute a more expensive service for one which had been eliminated or restricted, the State may realize a net loss. For example, one study found that a restriction in the drug formulary in Louisiana resulted in a $4.1 million decrease in pharmaceutical costs but was associated with a $15.1 million increase in total program costs brought on, in particular, by an unexpected increase in hospitalization by the disabled and the aged.[6] If denial of a $10 prescription leads to a $1,000 hospital stay then, clearly, the elimination of the specific drug should be reconsidered.

Finally, once a package of options has been selected and cost savings attributed, the State should explore the feasibility of implementing these changes. Specifically, the following should be examined: procedural channels which must be traversed; administrative capacity to carry out the change; political resistance on the part of providers and clients; additional burdens that will be placed on providers and clients; and, the likelihood of providers dropping out or reducing participation in the program.

CHAPTER II

MINIMIZE OR ELIMINATE THE USE OF OPEN-ENDED OR PROVIDER-CONTROLLED NURSING HOME, HOSPITAL AND PHYSICIAN REIMBURSEMENT SYSTEMS

The methods employed by private carriers, by Medicaid and Medicare to reimburse providers have contributed greatly to the extraordinary rate of inflation in the health care sector.[1] These reimbursement methods are generally based on reasonable costs or reasonable charges, where reasonable is usually defined in terms of provider behavior. As such, these payment techniques share a common characteristic, viz., they delegate control to the individual provider or to providers as a group.

The terms "cost" and "charge" are frequently and incorrectly used interchangeably. "Costs" are what a producer must pay to purchase the goods and services required to produce a particular health care or medical service. "Charges" are the prices billed to the consumer who buys the goods or services. Until recent changes were adopted in federal policy, state Medicaid programs either had to reimburse hospitals for the reasonable costs they incurred, as defined by Medicare principles of reimbursement, or obtain federal approval of an alternative definition of reasonable cost.* Many states reimburse physicians according to the "Usual, Customary and Reasonable" (UCR) "charge" for a particular service. Such physician charges are considered reasonable if they are within the 75th percentile of the charges of other physicians in a particular specialty group within a particular geographic area.

Reasonable cost reimbursement and UCR were originally adopted because they were helpful in gaining provider participation in Medicaid and Medicare. Moreover, such methodologies reflect differences among providers, respond rapidly to changes in the medical system, and, therefore, enhance the access of recipients to "mainstream" medicine. While these methods for payment initially produced considerable benefits for both providers and clients, they also produced a high rate of inflation—with government acting as a funnel for public funds into the health care market—and a misallocation of health resources and public revenues.[2]

Reasonable cost reimbursement gave hospitals considerable latitude to pursue their own institutional goals which often were at odds with public goals. For example, while every hospital might desire the most sophisticated technology available for performing the most esoteric procedures, a more efficient public approach might be to parcel out that technology among specified tertiary care hospitals. Reasonable cost reimbursement,

* The Omnibus Reconciliation Act of 1981 completely revises federal guidelines under which states must reimburse hospitals. For a detailed explanation of the change in federal law, refer to Appendix A.

however, encourages the former.[3] Reasonable cost reimbursement for hospitals is also the most lucrative Medicaid payment method. When States curtail reimbursements to other provider groups such as physicians or nursing homes, but allow hospitals to remain on a reasonable cost basis, they implicitly encourage the use of inpatient hospitalization as a substitute for these less costly services. For example, recipients would stay in a hospital because a nursing home bed could not be "found" or doctors would perform an operation in the hospital that could have been done in the office.

With regard to physician reimbursement, UCR permitted questionable differentials in prices among medical specialties and geographic regions. Because reimbursement is higher in specialties and regions that already had an excess of providers, the reimbursement system tended to reinforce the existing maldistribution of physicians.[4]

Nursing home reimbursement has been less tightly defined by the federal government; therefore, States have had considerable leeway in the design and operation of their nursing home reimbursement systems. Nonetheless, costs incurred within the industry remain a standard by which the federal government assesses and approves a state's reimbursement policies and practices.

The following section will explore how States can increase their control over reimbursement rates for nursing homes, hospitals and physicians. It should be noted that if a State tightens only its Medicaid reimbursement system (as compared to comprehensive rate setting for all providers), providers will be less likely to serve Medicaid recipients.

Nursing Home Reimbursement

Expenditures on nursing home services are the largest and most rapidly rising component of Medicaid outlays, accounting for 42.3 percent of total expenditures nationwide in FY 79. From FY 77 to FY 79, Medicaid expenditures for nursing home services increased about 35 percent, from $6.4 billion to an estimated $8.76 billion, while Medicaid expenditures for all other services increased 16 percent, from $10.1 billion to an estimated $11.7 billion.[5] While other policies, notably Certificate of Need or licensure standards, can also affect nursing home costs, reimbursement policy is a very powerful instrument for influencing expenditures. In fact, a number of States expressed an urgent concern that changes in state nursing home reimbursement policies pursuant to the 1976 congressionally-mandated requirements for reasonable cost-related reimbursement resulted in substantial cost increases.

The dramatic difference in increases cited above between nursing home and other Medicaid service expenditures indicates that such concern is warranted. Prior to 1977, differences in the rate of increase for the nursing home component relative to overall expenditure increases was substantially less. From 1974 to 1976, for example, the rate of increase in Medicaid expenditures for nursing home care was 47 percent while expenditures for other services rose 38 percent, a much smaller difference in the rate of increase than the growth in 1977-79. While data are not available to determine the precise reason for the unusually high relative increase in nursing home costs since 1977, one probable cause was that cost-based reimbursement policies contained little incentive for efficiency. Another possible reason was that confusion over ambiguity surrounding federal regulations resulted in some States adopting Medicare's costly reimbursement principles. Recent legislation has replaced Section 249(a) of the 1972 Social Security Amendments (the amendments requiring reasonable cost-related nursing home reimbursement policies), once again changing nursing home reimbursement policies. States are now mandated to make payments to nursing homes which are "reasonable and adequate to the costs which must be incurred by efficiently and economically operated facilities."[6]

Medicaid nursing home reimbursement policy is an unusually potent policy instrument because Medicaid is the largest purchaser of nursing home services, accounting for an estimated 45 to 46 percent of total nationwide nursing home expenditures. Because

Medicaid patients also contribute whatever pension, retirement or unearned income they might have toward their expenses, a more accurate measure of Medicaid's impact is its direct expenditures plus Medicaid recipients' contributions. In some States, this represents more than 70 percent of the nursing home's revenues.[7] Thus, Medicaid reimbursement policy can greatly influence the characteristics of long-term care in a State. For example, generous capital cost reimbursement policies can provide powerful incentives for capital replacement or expansion. Reimbursement policies can affect the location and size of homes, and the type and quality of care provided. If Medicaid policies result in expansions of nursing home capacity, state funds that may be spent more appropriately on noninstitutional long-term care, appropriate acute care and other services, will, instead, be diverted to nursing homes. For these reasons, States should design Medicaid nursing home reimbursement policies carefully and thoughtfully to achieve desired policy objectives.

Federal Policies

Current legislation requires States to set nursing home rates "in accordance with methods and standards developed by the State which the State finds and makes assurances satisfactory to the Secretary are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable state and federal laws, regulations and quality and safety standards; and such State makes further assurances satisfactory to the Secretary for the filing of uniform cost reports by each (facility) and periodic audits by the State of such reports."[8] In the conferees' report from the Senate and House, Congress indicates that it does not intend that the States set rates "solely on the basis of budgetary appropriations."[9] (Presumably, future regulations will clarify this phrase). The conferees also noted that the Department of Health and Human Services (DHHS) should review state plans in a timely fashion and that if DHHS has not acted on a State's plan within 90 days, then that State shall presume that it has been granted federal approval.[10]

Detailed regulations have not yet been issued, but it appears that States have been given greater authority than they had under Section 249. The legislation governing minimum payments provides States with reasonable flexibility to develop methods of reimbursement. Clearly, States must set rates that take into account actual costs of allowable items and reimburse costs in full if the facility is economically and efficiently operated. The standards for defining economically or efficiently operated are left to the States.

The flexibility granted to the States under this new system must be stressed. For example, the States could reimburse at the level of the lowest-cost provider who meets licensing and certification standards. The State must demonstrate that this home typifies costs which are obtainable by other economically and efficiently operated facilities in the State. A standard of this nature was suggested in the New York Moreland Act Commission study of that State's nursing home reimbursement procedures for operating costs. Specifically, the Commission recommended the adoption of a payment mechanism based on "Efficient Care Standards." Under the new method, nursing home costs, broken down by cost centers, would be regressed on a number of independent variables (size, patient mix, location, etc.). Each home would have had its rates set by classifying the home according to the relevant independent variables and then summing the regression's estimated costs. Additionally, standards for acceptable care would be set by low cost homes providing acceptable care. These homes would be used as Efficient Care Standards (ECS); that is, their cost would become a standard for the industry and reimbursement would be set accordingly. If the ECS were lower than the rates suggested by the regression analysis, then ECS would have to be used.[11]

Options for Controlling Nursing Home Reimbursement Rates

Congress has indicated that it does not want States to use budgetary constraints as the sole criteria for setting reimbursement rates. However, it would be difficult for a State not to address the projected and actual shortfall in its Medicaid nursing home budget in the structure of the reimbursement system. Before devising an overall strategy, a State should ask the following questions: Have nursing home expenditures increased at a rate greater than expected? How much of that increase was due to inflation, to increased utilization, to shifts to higher levels of care, and/or to an increased number of patients?

The nature of the increases is important because different mechanisms are suitable for controlling different problems. For example, redefining allowable costs would be a useful way of addressing rapid inflation, while shifts to more intensive levels of care could more effectively be addressed by changes in the rate difference between Intermediate Care Facilities (ICFs) and Skilled Nursing Facilities (SNFs). The absolute number of beds, number of beds certified for Medicaid use, the number used by Medicaid recipients, the geographic area and care level distribution also should be incorporated into the reimbursement system. If, for example, there are larger queues for beds in urban areas than in rural, a review of rates might lead to an increase in urban rates and a smaller increase or a freeze for rural rates.

Reducing Reimbursement Rates

This is an obvious way of cutting costs. Given the wide range of methods from which States can choose for reimbursing nursing homes, only those options which represent a leaner approach to reimbursement are discussed below. It should be remembered that reduced reimbursement will inevitably produce a decline in the number of beds available because it will discourage providers from accepting Medicaid patients and/or investing new capital in the industry. States may achieve similar objectives through limitations on access in lieu of reducing reimbursement. This option is discussed in greater detail under the section, *Restructuring the Medicaid Program.*

Cost Disallowance and Multiple Screens

Regardless of whether facilities are reimbursed on an individual facility basis or at a rate reflecting industry performance,[12] the calculation of the rate depends on the definition of allowable costs and the acceptable upper bounds for a given set of costs or of total costs. The following costs should not be recognized as "allowable" for Medicaid reimbursement:

- costs disallowed by Medicare;
- costs which improve the industry's political and legal leverage over the State (e.g., political contributions, association dues, legal fees for unsuccessful suits);[13]
- management fees for chain operated homes if these homes do not demonstrate distinctly lower costs for providing acceptable care than homes which are not chain operated; and
- travel outside the State.

In addition, if there is a sufficient number of beds in the industry, and if the growth rate has been at or above desired levels, any profit allowance or return on equity should be carefully reviewed.

Some States have unintentionally included inflationary incentives in their systems by reimbursing whatever it costs the nursing homes to purchase a given input. This practice allows the homes to pass on their costs, however inflated, to the government and other payers. Eliminating such unnecessary pass-throughs can result in cost savings. Some pass-throughs are inescapable in the short run, however, particularly for goods and services essential to the well-being of the patients, but whose costs are highly volatile and beyond the control of the homes, such as heating fuel. States should carefully examine other pass-throughs that may contribute to or provide incentives for increased costs. For example, in

the past, the only limit some States would place on allowable interest expenses was that the interest rates were "reasonable" and reflected market activity. Essentially, these States made the nursing home industry impervious to economic signals and monetary policy. If interest rates were very high and private construction and investment were low, nursing homes would be unaffected because excessive borrowing costs would be passed on to the State.

Setting Reimbursement Limits

What constitutes a reasonable reimbursement rate or rate ceiling for a nursing home is unclear. Setting an industry-based limit at the 75th percentile is no less arbitrary than setting it at the 50th percentile. Limits on rates can and should change over time depending on the number of beds available, the size of the Medicaid queue, the quality of care being rendered and the extent to which the industry manipulates its costs.

Rates should not be open ended; they should not rise endlessly with the costs incurred by the facility. There must be a cap on total costs. This can be done by setting limits for individual line item expenses (e.g., individual administrative salaries), for cost centers (e.g., nursing, dietary, housekeeping, etc), or for the total allowable costs. If all costs are capped, then the more focused the limitation and the greater the control. Oklahoma, for example, has identified 24 cost centers within each home and reimburses for each cost center up to the 60th percentile of the cost experience in each peer group of homes. As a result, total costs are not likely to equal the 60th percentile because differences in accounting procedures and behavior will mean that homes whose total costs hover around the 60th percentile will likely experience internal variations within cost centers; some at the 70th percentile, others at the 50th. Since costs will be reimbursed only at the 60th percentile or lower for each center within the home, the total amount reimbursed will be less than the 60th percentile. In contrast, setting limits for total costs gives homes more flexibility, allows them to adjust for inefficiencies in one area (e.g., dietary) by improving their performance in another (e.g., housekeeping), and is more amenable to slight variability in accounting practices (e.g., one home might treat a nurse's meals as a nursing cost; another, as a dietary cost). On the other hand, caps on total costs are less effective for reducing total expenditures than limits placed on individual cost centers.

It should be stressed that the use of any percentage limitation assumes that those caps coincide with acceptable normative standards within the industry. However, percentage limits are frequently used because they are an easy way to cap costs. Periodically, therefore, States should consider checking the validity of their limits with selective analysis of nursing home operations by industrial engineers.[14]

If a State reimburses nursing homes using a prospective rate with a trend factor or inflation index to project costs forward, that index should not be based solely on the performance of the nursing home industry. Instead, it should be based on broad categories of economic behavior (e.g., wages of service workers), and be restricted as much as possible to the State or to its region. Considerable care should be taken in selecting an index. The ever-popular CPI has a number of problems: it represents an array of goods and services that generally does not change; it represents some goods and services which are not appropriate to nursing home costs; it over-estimates some costs (such as housing) and underestimates other (such as medical care); and, it pertains only to metropolitan areas of a State, which may not be typical of the State as a whole. A more suitable index might be the GNP deflator or the Nursing Home Input Price Index developed by DHHS.

Reimbursement for operating costs should attempt to minimize expenditures for administration and indirect care, and maximize the proportion of operating costs devoted to direct patient care such as nursing and food. This does not mean that administrative costs are unnecessary, but that the State should pay only what is necessary to bring a reasonable quality of administration into the market. If a State keeps allowable administrative costs too low, the result may be poor administration and overall inefficiency of nursing homes.

Administrative costs can be limited, for example, by placing caps on administrative salaries as well as on the cost center. In addition, demanding on-site performance by the administrator would minimize the number of "nonproductive" members of the owner's family on the administrative payroll.

When a State tightens its reimbursement system, it will also affect the services provided by its facilities. For example, in response to lower payments, the nursing home could alter the amount and quality of meals it provides, reduce the nursing staff, or change the linen less frequently. States have three basic options to deal with a potential decline in quality. First, if current state requirements exceed federal requirements, the State can consider reducing its standards. This will not necessarily result in a decline in the quality of care patients actually receive. Indeed, some regulations have little to do with the quality of care a patient receives. Thus, States could consider reviewing quality standards and eliminating those regulations which do not appear to bear on the care that is provided to the patient or on the patient's health. In other words, the State should not regulate activities which simply do not matter.

Second, States can embark on aggressive utilization control programs that go beyond paper review to on-site patient observation and assessment.

Third, in conjunction with utilization review, States can design a reimbursement system around the individual medical, social and psychological needs of each patient. Only three States[15] have implemented this approach to reimbursement: Illinois, West Virginia and Ohio. While it is complicated, expensive, and requires considerable lead time, this is an important innovation which warrants further discussion. The Ohio system, which is now being implemented, is an excellent example of a patient-related reimbursement system and what it promises to do.[16] However, this is not primarily a method for cost containment but for assuring that the State defines and gets what it is paying for and that the patient receives what he needs. Ohio assesses patients in terms of 14 areas or standard services routinely provided in a nursing home[17] and 6 habilitation standards.[18] Within each standard there are three or four categories or service units representing a frequency or range of services delivered. For example, under the standard, "Intravenous/ Subcutaneous Fluid" a patient may be described as needing a) no service, b) 1-48 therapy hours, c) 49-96 therapy hours and, d) more than 96 therapy hours. In this particular instance, the service units are objective and unambiguous, although the initial decision as to how much care a patient will need will require a judgment by the State's review team.

Each service unit is then assigned a dollar value based on three factors: 1) The time required to deliver the service as determined by a special time study. (Ohio has performed a detailed and rigorous time study of 600 patients in six nursing homes determined by state officials to offer quality care. From 100 to 400 observations were recorded for each service unit); 2) A weighting factor which includes indirect costs, ranging from nurse participation in physician rounds to coffee breaks and sick leave, and public policy incentives such as encouraging the home to maintain the patient at his highest level of independence; and 3) Wages for personnel with the skill level required to provide the designated service unit.

The assignment of costs for assistance in eating (see Table I) offers an example of how the system works. The service units are listed in order of patient debility. Because the state has a preference for keeping the patient from tube feedings as long as possible, it has provided the homes with an incentive to maintain spoon feeding for marginal patients through the weighting factor. The dollar values for all of the service units required by each patient are added, and then summed for all patients. This sets the ceiling on state expenditures for all patients in the home. The state then pays actual costs up to the ceiling and nothing for costs that exceed the ceiling.

The actual assessment of patients (and the determination of required service units) is supposed to be done quarterly by a team of two RNs; a physician and a social worker are supposed to supplement the review at least once a year. The review was designed to consist

of a careful examination of the patient "to identify discrepancies between the observed patient's condition, the patient's condition as reflected in the plan of care, and the services delivered as reflected in the medical records."[19] These reviews will generate a number of reports which will be used to monitor and analyze the composition and change in the nursing home population and performance. The reports will permit the state to monitor the types of services needed and the services actually delivered to each patient in every participating nursing home; provide a detailed facility profile which indicates not only what services were provided but also whether patients received unnecessary services; show labor needs and utilization within each home for RNs, LPNs, aides and therapists; and provide a basis for statewide comparison of nursing home facilities. The progression from the individual patient to the industry as a whole greatly improves a state's ability to judge, control and upgrade performance within the nursing homes (see Table I).

Table I

EATING

Standard: The provision of necessary assistance and supervision to patients for the intake of food, fluids, and sustenance for adequate nourishment. This standard includes nasal-oral-gastro tube feedings prescribed by a physician and provided by an RN, or gastrostomy tube feedings prescribed by a physician and provided by an RN or an LPN under the supervision of a registered nurse.

Service Units:

A. Independent—no service.

B. Assistance and supervision—the patient requires supervision and *some* assistance from a staff member; e.g., cutting meat, buttering bread, opening cartons, pouring milk on cereal or cream in coffee with frequent encouragement or reminders from the staff for maintenance of a proper diet. This standard also includes appliances used to assist the individual in eating, and routine daily living skills provided as reinforcement or continuation of a daily living training program.

C. Spoon Feed—Applies to the patient that is totally fed by a staff member because he cannot bring food to his mouth independently. This category includes the patient who can occasionally bring food to his mouth in an effective manner.

D. Gastric Tube/Gastronomy Feedings—Patient is fed a prescribed diet via an N-G tube. This category includes the insertion of the N-G tube by an RN and care of the gastronomy opening or feeding through the tube by an RN or an LPN under the supervision of an RN.

Control in the system will rely heavily on incentives built into the reimbursement methodology. In addition to the incentives for rehabilitation and maintenance of function, The Ohio system contains several other important incentives:

- *Unnecessary Institutionalization*
  The patient reviews will not only identify individuals who do not need to be in a nursing home but will result in a reimbursement rate for those patients that is lower than the cost necessary to keep a nursing home bed certified. This should encourage physicians in the homes to discharge those patients who do not need institutional long-term care. Because those patients identified as not needing nursing home care are referred to local welfare offices for placement elsewhere, the low reimbursement rate should encourage the homes to cooperate with the local welfare system. Further, if the local welfare departments do not demonstrate adequate effort to place a patient back in the community, the county welfare department loses the federal FPP for that client.
- *Undelivered Services*
  The Ohio patient assessments will identify whether the services required by the patient were actually delivered. If a necessary service was not provided, the imputed dollar value of that service is subtracted from costs which were incurred by the facility on behalf of Medicaid patients.

- *Unnecessary Services*
  If services are provided which were not ordered by the patient's physician or indicated by the patient's plan of care, then the State will not pay for those services.

The biggest problem with this system is that it requires intensive monitoring by the State and an ongoing commitment to fund the survey teams. Existing cutbacks in Ohio's program have resulted in a reduction in the number of nurses assigned to survey teams. Patient reviews have fallen behind schedule and nursing homes are complaining about the quality of the reviews that are being done. Other problems seem to be plaguing the system and its future is unclear.

Reimbursing Capital Costs

Reimbursement for capital costs has often been a highly political issue even though it represents only 10 to 15 percent of nursing home costs. These costs can be minimized if:

- the value of the home is placed at its historic cost, which tends to be lower than market or replacement value;
- the facility is imputed a useful life of 40 years, which remains unaltered regardless of whether it is sold (40 years is the maximum recommended by the Internal Revenue Service (IRS) and the American Hospital Association—the longer the useful life, the lower the annual depreciation);
- interest rates are tied to the prime rate of a major bank in the State and no interest expenses will be paid in excess of that rate. If the prime rate is too high—a judgment based in part on the need for additional beds—the State should set its maximum reimbursement below the prime rate;
- regardless of whether a home is bought or leased, it is treated as if it were owned. This eliminates real estate transactions such as sales-leasebacks which are designed solely to increase reimbursement. It can be done on an individual facility basis (as in New York) or on a peer group basis (as in Illinois) where capital costs are reimbursed according to the average age- and size-adjusted capital cost groupings.[20]

States may also eliminate reimbursement for returns on equity. However, equity in the industry is already low, so eliminating reimbursement may not result in appreciable savings. In fact, it would encourage owners to minimize the equity they have in their homes by continually refinancing up to the limit allowed by the reimbursement system.

Other Reimbursement Restrictions

States can also adjust their rate-setting practices to reflect the different levels of care required by ICF and SNF patients. For example, States frequently permit a home to provide both SNF and ICF care. In those instances, the State should pay less for ICF care than for SNF care. The ICF rate can be set as a percentage of SNF care (e.g., in 1974 Minnesota reimbursed ICF care at 85 percent of the SNF rate[21]), or it can be set so that a patient requiring only ICF care receives the ICF rate whether he is in an ICF or an SNF.

Finally, the State can support a dual system of nursing home programs. For example, Missouri supports both a Medicaid nursing home program and a totally state-funded nursing home program which is open to anyone eligible for any state welfare program. The latter provides a $300-a-month stipend to patients in licensed (but not necessarily Medicaid-certified) homes. If a patient is receiving an SSI check, he retains the total amount he had been receiving while not institutionalized. (If he had been in the Medicaid system, his SSI payment would have dropped to $40 as soon as he entered the nursing home.) The homes can require family supplementation, which is not allowed under Medicaid. Thus, families who could not otherwise afford the total cost of placing a family member in what they consider a good nursing home can do so under this program. An additional benefit from a dual system is that older facilities which fail to meet the federal life safety code but are considered safe by the State can continue to operate.[22] A clear disadvantage is that homes which do not meet the life safety code are more prone to disastrous fires than those that do meet the standards.

Administrative Options

The States have a number of administrative options which do not require changes in the reimbursement system but nonetheless allow the State to either save money or improve its bargaining position with the homes.

If the State can increase the speed of payment to nursing homes, it can reduce state expenditures if those expenditures recognize interest on working capital and if loans for working capital are necessitated by the State's existing practices. This action has the added advantage of improving the nursing home's cash flow. At the same time, it should be noted that any improvement in the nursing home's cash flow has a negative effect on the State's cash flow. The State should also consider implementing a common audit between Medicaid and Medicare. Further, tape-to-tape billing could significantly reduce costs (although depending on the size and sophistication of the home, tape-to-tape billing should be optional and not mandatory).

The State should make a concerted effort to audit its homes as frequently as is necessary.[23] This permits the homes to understand state procedures more clearly, prevents placing homes in a situation where they are forced to repay the State $500,000 in one year for 10 years of misinterpreting the same regulation, and prevents the State from continually paying for costs which should not be reimbursed. In addition to frequent audits, the State might consider charging a home interest for excess payments made by the State. This would be an added incentive for the homes to make sure that they understand and properly interpret state regulations.

Reducing or eliminating payment for empty beds while a patient is visiting home or hospitalized may also reduce nursing home costs. However, this reduction may be offset by several adverse results, not the least of which is an increase in hospital costs. If States do not pay for the empty beds of patients receiving care in the hospital or visiting relatives at their original homes, then nursing homes may accept new patients to fill those temporarily vacant beds. One costly outcome would occur if a hospitalized nursing home patient was unable to return to the original nursing home because the bed was filled. This could lead to an increase in the number of costly hospital "administrative" days, i.e., days that patients must spend in a hospital because alternative placement cannot be found. If patients were aware that this might happen, they might not leave the nursing facility to visit home, thereby increasing their dependence on the nursing home. Further, it may produce unfavorable publicity; that is, charges that state policy restricts the mobility of patients. The State must, therefore, carefully consider the potential tradeoffs before implementing such a strategy.

Hospital Reimbursement

Expenditures for hospital services accounted for more than 31 percent of nationwide Medicaid expenditures in FY 79.[24] For several States, hospital costs represent the largest component of Medicaid costs. Proposals to contain overall health care cost escalation frequently focus on hospital costs because: a) they represent the largest single component of national health expenditures—40 percent of national expenditures in FY 79;[25] b) a hospital is generally the most intensive and costly medical setting; and, c) hospital costs, in recent years, have consistently risen at a higher rate than other health care costs.

Retrospective cost-based reimbursement policies have contributed significantly to increased costs. Medicaid programs that use Medicare principles of reimbursement have very little control over the rate of increase in expenditures for hospital care. Available data suggest, however, that alternative reimbursement structures can reduce the rate of hospital cost increases. For example, total community hospital expenses increased by 8.6 percent in 1978 in the eight States with ongoing mandatory hospital cost containment programs, while they increased by 14.0 percent in the rest of the nation.[26]

Medicaid reimbursement policies alone are unlikely to have a significant effect on

total hospital costs because Medicaid accounts for only 11.5 percent of total expenditures for hospital services. In instances when Medicaid does act alone to contain costs, such efforts usually result in many hospitals refusing to accept Medicaid beneficiaries or limiting their participation in the program. These efforts can also force high-volume Medicaid hospitals—typically public and teaching hospitals—to bear the full impact of cost containment measures.

Federal Policies

Before the advent of the 1981 Amendments to Title XIX, inpatient hospitalization under Medicaid could be reimbursed in one of two ways: Medicare's reasonable cost reimbursement or an alternative approach approved by DHHS.* Reasonable cost reimbursement is intended to recognize costs which are "necessary and proper" and which are "related to [the] care of beneficiaries." The policy also requires that Medicaid patients neither subsidize nor be subsidized by non-Medicaid patients; that the State adopt Medicare's principles and standards; and that Medicaid apply payment limits established by DHHS.

In operational terms, reasonable cost is derived by auditing a hospital's books, identifying that fraction of total charges which are Medicaid charges and multiplying that fraction by the total cost of operating the hospital. Technically, this is referred to as the "ratio of charges to charges applied to costs" or, RCCAC.

In lieu of the Medicare formula, States could design an alternative reimbursement method, but had to obtain DHHS approval to apply it.[27] In general, the alternative system had to:

- provide incentives for efficiency and economy;
- assure that payments do not exceed Medicare's reasonable cost rate;
- assure adequate hospital participation and the availability of high-quality services;
- include an adequate appeals mechanism; and
- not allow payments in excess of the lower of reasonable costs or customary charges to the general public. (This requirement also applies to Medicare's reasonable cost method.)[28]

States have considerable leeway in setting payment for outpatient hospital services. Federal regulations specify only maximum reimbursement levels; that is, States may not exceed the Medicare payment levels for providing comparable services under comparable circumstances. There is no explicit minimum reimbursement level, only a requirement that rates be sufficient to assure "adequate" access. "Adequate" is undefined.

Options for Controlling Hospital Reimbursement Rates—Alternative Reimbursement Methods

Alternative reimbursement methods can include one or more of the following components:

- the cost base of a hospital can be inflated according to an "economic trend factor" which is applied to all hospitals in the state, adjusted for homogeneous hospital groupings or adjusted for each hospital (the same principle behind many rate-setting proposals);
- use of peer groupings of hospitals as the standard for setting limits;
- reasonable utilization limits such as an imputed occupancy rate;
- an appeals process; and
- specific regulations.[29]

Clearly, creating a totally new alternative is a costly, difficult and lengthy process. Before embarking on such an endeavor, States should recognize that federal reimbursement requirements entail a certain amount of ambiguity usually resolved only when the

*See Appendix A for a detailed explanation of the recent changes in federal law covering hospital reimbursement policy under Medicaid.

federal government reviews alternative plans for approval. Guidelines, like preambles to either legislation or regulations, are instructive but neither carry the force of law nor guarantee that guidelines will be applied in a consistent manner. The process is uncertain, particularly when the federal standards are not specific. Federal judgments, therefore, are often ad hoc. States whose alternative plans are denied should demand justification for the denial and ask to see all of the alternative plans which have been approved.

Heretofore, obtaining federal approval for alternative plans has been a lengthy process. States seeking to alter their reimbursement procedures may wish to consider adopting one of the federally approved alternatives in toto, or in a slightly modified form. Because these are alternative approaches to hospital reimbursement which are approved by the federal government and not a waiver demonstration project, it might be acceptable to adopt another State's approach. This not only reduces development time but also federal approval time since the system has previously been deemed acceptable. The federal government, however, will not automatically grant approval to States wishing to adopt a previously approved system. Rather, a State will have to demonstrate that whatever method it submits for federal approval is structured to meet that specific State's needs. The particular needs of each State are subject to federal interpretation; hence, States should prepare extremely detailed and well-reasoned briefs justifying their proposed use of a particular alternative plan.

States should consider a number of factors before selecting an alternative system. First, the sophistication of the State's Medicaid system must be examined. For example, does the State use a fiscal agent? If so, can the contract be altered in midstream? How well has the State performed its reimbursement function? Would the legislature increase appropriations for necessary staff and hardware? Have the State's hospitals participated in reimbursement experiments, or have they been subjected to other state rate-setting efforts?

Second, the immediacy of the problem must be taken into account. How quickly must the reimbursement system be changed? What is the projected shortfall in Medicaid expenditures for hospitals? Have increases in hospital expenditures been in excess of Medicaid's projections? Third, the cause of the increase must be examined. Is the increase peculiar to Medicaid, or is it also the experience of other major third-party payors and the State as a whole? Can the increase be broken down; that is, how much is due to inflation, increased utilization, increased service intensity and increased welfare rolls? Understanding the cause of the increase is important because different changes in the Medicaid delivery system suggest alternative methods for intervention. Reimbursement constraints are more suitable for treating rapid and large increases due to inflation than they are for addressing changes in the intensity of services for which utilization controls may be more effective. Further, understanding how Medicaid functions not only permits the proper selection of control mechanisms, but also allows for comparisons to the private sector. If large increases in inflation and intensity are restricted to Medicaid, the State should initiate a large-scale audit of all high-volume Medicaid providers and the fiscal agent.

Finally, the political clout and potential resistance from the hospital industry are factors which cannot be ignored. In general, as the political influence of the industry increases, it becomes more difficult to alter the status quo, the State's case for imposing restraints must be more compelling, industry involvement in the design of the constraints must be greater, and the adjustments, exceptions and appeals process must be applicable to a wider number of providers.

After addressing the above issues, States should opt for an alternative system that combines the following features:

- It should be as simple as possible to operate. Simplicity will reduce the time needed to implement the alternative, as well as the time necessary for providers and state administrators to understand the system;

- It should permit as few adjustments, exceptions, pass-throughs and justifications for appeals as possible. This will make the system more readily comprehensible, reduce administrative difficulty, and limit the ability of providers to manipulate and circumvent the reimbursement methodology;
- It should base its cost guidelines or limitations as much as possible on nonhospital industry performance. Because the hospital industry historically has experienced inflationary increases above that for other goods and services, the State should select cost limits justified in terms of national or statewide economic trends and which result in expenditures lower than those which would have been observed if no limits were in place or if the hospital industry experience was used as a base. A National Hospital Input Price Index, which attempts to measure the rate of increase of the market basket of goods and services purchased by hospitals, has been developed by DHHS. DHHS is also developing separate indices for each of the nine census regions. These indices are promising tools for States in selecting cost guidelines or limitations; and
- It should involve the participation of other major third parties such as Blue Cross and Medicare. Involving other payers minimizes hospital discrimination against Medicaid patients.

Presently, 11 States reimburse Medicaid hospital expenditures according to alternative plans: Idaho, New York, Massachusetts, Michigan, Wisconsin, Rhode Island, Colorado, California, Florida, Mississippi and New Jersey. In addition, the Medicaid program participates as a payor in experimental payment systems conducted under demonstration and waiver authorities in Maryland, New Jersey, Georgia, and Rochester, New York. Summarized below are the alternative systems of Idaho, Michigan and New York, which represent an array of possibilities ranging from the simpler approach in Idaho to the more complex in New York. New York's program is viewed by federal administrators as the most stringent permissible. It should be stressed, however, that no specific federal regulations set forth what the most stringent acceptable system would be like.

In Idaho, hospitals are reimbursed the lesser of customary charges, Medicare's reasonable costs, or Idaho's alternative. The alternative consists of fixed costs (capital costs as defined and reimbursed under reasonable costs) and operating costs reported in the previous fiscal year multiplied by a hospital cost index. This is a composite index specifying allowable rates of increases for wages and salaries, food, malpractice insurance, and other nonspecified variable costs. Marginal adjustments are made for volume charges.[30]

Michigan uses two reimbursement methods: one for hospitals representing the top 20 percent in volume, and one for all other hospitals. The first approach reimburses fixed costs (defined by Medicare and prorated by Medicaid) and operating costs based on the lesser of actual costs, or an Individual Hospital Limitation on Expenditures (IHLE) which is historic operating costs adjusted by a hospital cost inflation index. The IHLE can be adjusted for changes in volume and intensity in service provisions. The second reimbursement approach, which applies to the top 20 percent of hospitals in the volume of Medicaid days, pays on the basis of a budget review or an incentive reimbursement plan which will reward a hospital if it stays under its IHLE. The remaining 80 percent of the hospitals will be phased into a similar process over a four-year period.[31]

New York's alternative reimbursement system is an example which cannot be replicated easily. New York establishes rates prospectively based on historic allowable costs (exclusive of capital costs) and subject to screens established by peer groups, hospital cost experience, length of stay limitations, volume adjustments, and a trend factor.[32] An interesting component of New York's system is the length of stay (LOS) limitation, which excludes reimbursement for costs due to hospital stays in excess of LOS screens based on age and Diagnostic Related Groups (DRGs). This represents a potential conflict with PSRO authority to determine length of stay as discussed below.

A special set of alternative reimbursement approaches used in some States reimburses hospitals according to the costs of DRGs. New Jersey and Georgia are leaders in this approach.[33] However, because developing and implementing the DRG approach is a relatively lengthy process, it would not meet the immediate needs of many States. Under DRG systems, possible diagnoses are grouped into 83 major categories which are subdivided into 383 DRGs. (For example, under the major diagnostic category, Malignant Neoplasm of the Respiratory System there are five DRGs.) Each DRG serves as a basis for collecting utilization and cost data and each can serve as the basis for reimbursement. In two critical reviews, one by Russ Hereford and the other by James Bentley and Peter Butler, DRGs were identified as having the following advantages and disadvantages. On the positive side:

- DRGs are conceptually appealing because they 1) attempt to describe patterns of resource consumption in terms of the similarities among, and differences between, patients; 2) are based on patient diagnoses; and 3) consider secondary diagnoses and surgical and medical procedures provided to the patient;
- DRGs are organized hierarchically so that diagnostic groups can be collapsed into fewer categories which, while internally heterogeneous, are still useful;
- DRGs can be easily created using any of the major diagnostic coding conventions, except ICD-9-CM; and,
- DRGs provide hospital administration with additional tools to measure performance. The cost reports for each of the 383 DRGs permit a hospital to compare its costs and rates with the entire group of hospitals under the program. In addition, a DRG system can provide internal information on resource utilization and costs, both by cost center and by physician.[34]

Some negative aspects of DRGs include:

- DRGs rely upon data on discharge abstracts which often include classification and coding errors, fail to include all diagnoses and procedures, and vary by the documentation of the attending physician and the conventions of the individual coder;
- DRGs reflect the state of medical technology and practice at the time of their development. To account for advances in diagnostic procedures and therapeutic modalities, the DRGs would have to be updated frequently;
- The performance of a surgical procedure often categorizes a patient into a more complex DRG. Hence, if DRGs are used for reimbursement, and if the reimbursement method reflects the complexity of the DRG, surgical procedures may be encouraged because they result in higher reimbursement;
- An extremely large data base is required to create, evaluate or redefine the DRGs. In addition, if hospital cost or charge data is used as the dependent variable (i.e., resource consumption), the data base is doubled because both a discharge abstract and a hospital bill are required for each patient;
- DRGs only group and classify inpatients; DRGs for outpatients have not been developed;
- DRGs group patients into categories asserted to be homogeneous on the basis of the historical use of patient days. Thus, DRGs are neither a standard of what should be done nor a measure of impact of the pattern of care on the patient; and,
- Patients with coverage under the same third party payors historically use fewer or more services than the average. If the DRG system is based on the average costs of caring for patients with particular diagnoses (as in New Jersey), then some resistance may develop from third parties with lower than average experience. For example, New Jersey Blue Cross has indicated that the average length of stay for its patients is 6 percent below average, while Medicare patients exceed the average. Blue Cross believes that charges for its subscribers should reflect their shorter stays.[35]

Controlling Outpatient Costs

Fewer federal constraints are placed on outpatient reimbursement than on inpatient. Federal regulations specify only that payments cannot exceed outpatient service charges to Medicare. Below this ceiling, rates can easily be altered to reflect the availability, capacity and utilization of private physicians, free-standing clinics, hospital outpatient departments, and emergency rooms by Medicaid enrollees. In addition, rates could differentiate between emergency care, specialized outpatient services and primary care services which might best be provided in a physician's office. If a service should be provided in a physician's office, then that service should be reimbursed as if it were; i.e., at a lower rate. This approach, however, has several drawbacks. First, if a service should be rendered in an emergency room but is successfully provided in a physician's office, should the physician be paid at the emergency room rate? Further, if this approach were adopted in an area with a shortage of primary care clinics and private physician offices, then reduced rates for nonemergency use of emergency rooms could create hardships for clients and financial difficulties for the hospitals which provide a large amount of emergency room care to indigents. Reimbursement techniques alone, therefore, are not suitable for changing utilization patterns within outpatient departments and emergency rooms. Utilization controls and other forms of direct intervention needed to alter inappropriate behavior are discussed in the following chapters.

Administrative Options

States may also pursue a number of administrative strategies in order to achieve savings within the reasonable cost methodology. They can conduct a common audit for both Medicaid and Medicare, a measure which is currently in place in many States. Common audits save administrative costs by avoiding duplication. Such audits are now required under the Omnibus Reconciliation Act of 1980. Further, the processing of bills would be greatly improved if hospitals did not have to transcribe invoices from tape to paper only to have the State transfer the paper invoice to tape.[36]

Several modifications may be considered by States using either "reasonable cost" or alternative methods. To avoid paying for a disproportionate share of empty beds, an imputed occupancy rate could be used. The occupancy rate could be set at the imputed occupancy rate or at the actual occupancy rate, whichever is greater. Without an imputed occupancy limit, a State could pay an inordinate amount for empty beds. For example, if over a year only 60 beds of a 100-bed hospital were filled and 30 beds were occupied by Medicaid patients, then the State could be required to reimburse the hospital for half of the total operating costs necessary to run the facility.

The imputed occupancy rate can be set at the statewide average, at some desired rate; e.g., 85 percent,[37] or at different levels for different departments. In New York, for example, maternity wards have a minimum 60 percent occupancy level; pediatrics, 70 percent; and medical and surgical, 80 percent.[38] However, it is not necessarily advisable to impose occupancy limits on all hospitals. Excess capacity can be a secondary effect of meeting more pressing social goals. Thus, hospitals located in isolated or underserved areas and have low occupancy rates might be excluded from this requirement. Additionally, small hospitals should not be expected to attain occupancy rates as high as large hospitals because of the variability in daily occupancy rates in small hospitals. States must also consider whether to apply imputed rates to both variable and fixed costs.

The States cannot receive federal matching payments if they reimburse hospitals or other facilities for capital expenditures (large purchases of equipment, new construction or renovation) without certificate-of-need approval. However, the major costs associated with new construction or equipment are not the capital costs of the purchase itself but, rather, the costs of the personnel to maintain and operate the new physical plant or equipment. Therefore, States should avoid reimbursing hospitals for any costs—capital or

operating—associated with new construction or equipment which has not received approval from the state planning agency.

Frequently, States reimburse hospitals for legal expenses, including those incurred in suing the State, as well as for lobbying expenses, including association lobbying efforts to block the Medicaid agencies' efforts to contain hospital costs. In effect, the State frequently allocates more resources to hospital legal activities than it does for its own legal expenses. Therefore, the State should not reimburse hospitals for legal expenses incurred in unsuccessful suits brought against the State, political contributions or association dues.[39]

Because weekend admissions of patients operated on during the week are often expensive and unnecessary, the State should consider disallowing all costs associated with a weekend admission for nonemergency care. Such action falls under the State's right to limit the scope and duration of services.

Moreover, the State would reduce costs if it did not recognize percentage contracts for hospital-based physicians such as radiologists or pathologists. These physicians frequently receive a percentage of the billed services provided by their departments.[40] Percentage contracts often permit excessive incomes and do not discriminate between physician and technician services in reimbursement rates. A recent study by the DHHS Office of Inspector General found that Medicaid compensation for hospital-based pathologists and anesthesiologists had more than doubled over a two-year period, and that the enormous increase was unrelated to increases in utilization or physician costs. Rather, it was a function of percentage contracts, inadequate record keeping, and federal regulations which prevent Medicare intermediaries from interfering with reimbursement contracts between hospitals and physicians.[41] Rather than recognize percentage contracts, Medicaid could impute a maximum salary (e.g., $100,000), and then pay a prorated share of the physician's actual salary or the imputed maximum, whichever is less. Alternatively, reimbursement could be tied to the time and effort of the physician and limited to the fee-for-service charge for similar services. Because definitions of "time" and "effort" for all of the procedures provided by radiologists or pathologists pose tremendous problems, States would be well advised to use either an imputed maximum salary or a selectively manipulated fee schedule (as discussed below under Physician Reimbursement).

Laboratory and X-rays provided in hospitals should be reimbursed at levels no higher than the prices charged by large, private automated labs. This strategy would reduce costs, promote internal efficiency, and encourage hospitals to subcontract with private labs or form a consortium with other hospitals to purchase or produce lab services.

Michigan has adopted this policy for payment of its outpatient hospital laboratory services. When the policy was first proposed, there was resistance by the hospital industry and claims that the policy failed to recognize the differences between hospitals and independent labs. Michigan's review of its laboratory industry revealed the following:

- Hospitals perform approximately 50 percent of all laboratory services, with physicians and independent labs performing the other 50 percent.
- Quality control standards are virtually identical for hospital and independent labs.
- Compliance with hospital certification procedures mandates that a hospital maintain a 24-hour operation 7 days a week, but a hospital does not have to be fully staffed 24 hours a day—staff may be available "on call." According to 1979 data, approximately one third of Michigan hospitals were fully staffed for the weekend.
- Independent lab services are available throughout the State, including the upper peninsula and rural areas. In fact, some hospitals use independent labs as their sole provider of hospital lab tests, and many hospitals contract for partial independent lab service.
- The independent labs are profit-making enterprises that pay taxes on their earnings each year, whereas most hospitals are nonprofit institutions. The independent labs

are performing the same service at a reduced cost with equal quality and doing it at a profit with the fee-for-service rates.[42]

performing the same service at a reduced cost with equal quality and doing it at a profit with the fee-for-service rates.[42]

If other States choose to implement this approach they may have to exempt hospitals unable to subcontract with private firms. In addition, a method for reimbursing the cost of operating the hospital labs when private labs were closed would have to be resolved. At a minimum, lab reimbursement fees should be applied to all nonemergency, outpatient services.

Physician Reimbursement

Expenditures for physician services are the third largest component of Medicaid expenditures. They represent 9 percent of nationwide Medicaid service costs. More important, however, is the fact that physicians make decisions which directly influence virtually all other Medicaid costs. Medicaid physician reimbursement policies not only can help determine the costs of physician services and the willingness of physicians to participate in the Medicaid program, but they can also affect the volume, setting and costs of other services.

Federal Policies

According to Medicaid regulations, state reimbursement for physician services may not exceed the lower of:

- a physician's actual charge for a given service;
- a physician's "usual" charge or his median charge for that service. For example, if a dermatologist charged non-Medicaid patients $20 for an office visit, and Medicaid patients $25, the State should not reimburse the physician more than $20; and,
- the "customary" charge or the charge that does not exceed 75 percent of the "usual" charges submitted by physicians in the same specialty in the same geographic area during the calendar year preceeding the fiscal year for which the charge is determined. (Thus, if the same dermatologist charged Medicaid $25 for a brief visit, and his "usual" charge was $20, but the "customary" charge for dermatologists in his area was $18, the physician would receive $18.) There are two further stipulations. First, if Medicare has established a "customary" charge for a given service, and that charge is lower than Medicaid's, then Medicare's lower charge applies.* (In practice, many States simply use Medicare's charges and set their own for services that Medicare does not normally provide, such as pediatric or obstetric.) Second, Medicare's "customary" charge is also tied to an economic index which measures the relative weights and rates of increase for various cost components (e.g., office expenses, wages). Increases in the Medicare customary charge cannot exceed this economic index.

The State may use a system based on these Usual, Customary and Reasonable (UCR) charges, or set up a fee schedule which specifies rates for particular services. (In 1981, 25 States employed UCRs and 25 used fee schedules.[43]) In either case, UCR limitations set the maximum allowable reimbursement—unless a waiver is granted. Fee schedules usually differ from UCRs because fees are lower. In the absence of controls on unnecessary utilization, the lower reimbursement rates of fee schedules do not necessarily lower overall expenditures for physician services; that is, physicians might provide more services and/or more complicated and expensive services.[44] A further distinction between UCR and fee schedules is that UCR allows physician charges to determine reimbursement

* Medicare has defined Medicaid's "usual" charges as "customary" and "customary" as "prevailing." Thus, technically, Medicare's "customary" charges referred to in the text should be labeled Medicare's "prevailing" charges.

levels, while fee schedules allow the State greater discretion in the design of its payment mechanism.

In its unaltered form, UCR produces a floating set of charges governed by physician behavior. Each time the State limits its willingness to change with physician changes, the State imposes more discipline on its own program. As more and more limits are placed on UCR, the floating rates are replaced by fixed sets of permissible charges for well-defined procedures and the State control over fees increases. In addition, as more limitations are imposed, UCR increasingly resembles a fixed fee schedule.

Options for Controlling Physician Costs

States enjoy considerable flexibility in setting physician rates if they consider UCR as an upper limit only. States can control prices by limiting the rates of increase for UCR fees (e.g., holding fee increases to 5 percent a year), lowering the acceptable limit for customary charges below Medicare's 75th percentile (e.g., the 50th percentile could be used), or delaying their up-dates of physician usual and customary fee profiles. Further, States can limit rate increases to specific services based on some predetermined criteria; by selectively controlling UCR, for example, preference could be given for prenatal and infant care over more esoteric and episodic care.

The State could also eliminate medical specialty as a distinction for reimbursement rates. Appendectomies, for example, could be reimbursed at one rate regardless of whether they are performed by GPs or by specialists. Nevertheless, it may be wise to restrict certain sophisticated procedures to board certified physicians only (e.g., a coronary bypass). Requiring board certification, however, will probably increase the physicians' fees for the service and may reduce access to those services.

Eliminating rate distinctions between identical services performed in an inpatient and in an outpatient setting might reverse some incentives for hospitalizations. Whenever a service can be appropriately rendered in either setting, the State reimbursement should not exceed the outpatient rate. Indeed, given the high costs associated with unneeded hospitalization, the inpatient rates might even be set below the outpatient rates.

Finally, States might set a price ceiling for each disease episode. However, if this approach were diagnostic specific, it would almost be as difficult to implement as DRGs are for hospitals.

A note of caution is in order: lower fees are not necessarily beneficial. They tend to reduce physician participation in the program and can result in the client substituting more expensive care (e.g., outpatient and inpatient hospital services) for physician services. For example, in 1977 States allocated 10.3 percent of their total Medicaid expenditures to physician services. There was very little difference in this allocation between States using a fee schedule or UCR. However, a much larger percent of total costs were allocated for outpatient services and inpatient hospitalization in States with fee schedules than with UCR (e.g., States with fee schedules allocated on average 33 percent more for outpatient services and 25 percent more for inpatient services than UCR States).[45] While a number of other intervening and unrelated factors might explain these differences, such as utilization controls or hospital rate-setting activity, several explanations directly related to physician reimbursement are also relevant. For example, States with fee schedules reimburse at much lower rates than States using UCR.[46] Greater use of outpatient departments in States using fee schedules could reflect greater difficulty by clients to receive care in a physician's office than in States using UCR. Further, the higher level of inpatient hospitalization in States using fee schedules might reflect the added incentives physicians have to increase their income by providing more costly and more complex inpatient hospital services.

Further, if rates are too low, the availability of certain services may be curtailed. In one State, for example, Medicaid will not reimburse a physician more than $200 for any service.[47] Access to tertiary care, therefore, tends to be restricted to those services which

could be billed as hospital costs (e.g., services by residents or salaried physicians) or to physicians willing to subsidize Medicaid patients.

If physician behavior would change, the nature and structure of the entire health delivery system would be altered dramatically. Robert Derzon, the former Director of the Health Care Financing Administration, has suggested that one way States could alter specific physician behavior is by paying bonuses in addition to fees. Under current law, bonuses are not permitted. With a change in law or through waiver authority, States could pay bonuses for:

- using less expensive hospitals;
- lowering costs per hospital stay;
- increasing the ratio of outpatient surgery to total surgery;
- lowering the number of outside ordering profiles prescribed; and
- achieving high compliance with well developed medical protocol.[48]

A final option which might be considered is for the State to hire physicians, pay them a salary and place them in areas with high concentrations of Medicaid clients. A salaried approach is more amenable to administrative control over the cost of services than fee schedules. It can be attractive to physicians and has been used successfully to attract physicians to underserved areas (through programs such as the National Health Service Corps and Neighborhood Health Centers). As one authority has observed, "Salaried arrangements reduce risks and eliminate managerial problems, such as collection of bills, inherent in caring for poor populations. Thus, when salaried payment is coupled with an organized practice designed to serve target populations, it can contribute to an enhanced capacity to care for the underserved."[49]

Administrative Options

Administrative cost savings, as well as potential savings in benefit payments, might be realized if States reduced the number of billable procedures. This might control the practice of inflating fees by breaking procedures down into smaller and smaller units of services. States can reduce the number of billable procedures by employing a condensed version of the CPT4 (Current Procedural Terminology—the AMA-designated code book—has 6,000 terms) for reimbursement purposes, or by using all-inclusive billing—setting one fee for each diagnosis or major procedure.[50] The State also should reimburse at the rate in effect when services were delivered, not when the bills were submitted. Thus, a service performed six months ago should not be paid at current inflated rates.[51] Moreover, services ought to be reimbursed at the rate for the locality in which they are delivered, and not the rate for the locality from which the bill is sent. For States with substate localities, this would eliminate overpayments to physicians who practice in low-cost Medicaid regions but bill from administrative offices in high-cost areas.

CHAPTER III

MINIMIZE PROVIDER AND RECIPIENT MISUSE OF MEDICAL SERVICES

Unnecessary utilization of medical services is a serious and costly problem within the medical care delivery system. Improper utilization is related partially to extensive insurance coverage, consumer ignorance, the nature of the service, physician dominance, and the failure of third-party intermediaries to monitor behavior effectively. Examples of misuse of medical services include: doctor-shopping (or excessive experimentation by patients with a number of doctors for similar services which do not warrant second opinions); unnecessary surgery; unnecessary use of emergency rooms; excessive laboratory or X-ray services; and overlong or medically unjustified hospital stays.

Utilization controls encompass a large array of mechanisms designed to insure that only necessary and appropriate services are provided. Utilization controls are or should be an important part of any management approach to Medicaid cost containment. As Bruce Stuart notes:

> "It is not surprising that utilization control is considered a primary element in Medicaid cost containment policy, for it appears to offer something for nothing. Unlike benefit limitations or restrictions on eligibility, the client need not suffer any real reduction in program benefits if the control mechanism is properly administered. Likewise, a utilization control need not result in lower levels of remuneration per service to medical providers, at least not for those who meet the program's standards for medical necessity."[1]

This section reviews the federal and operational requirements for utilization controls and the following categories of utilization mechanisms:

- financial disincentives;
- provider/patient education;
- review mechanisms;
- authorization requirements; and
- controlled intervention and sanctions.

Much of the format, thought and several of the examples in this section are abstracted from an article by Bruce Stuart entitled, "Utilization Controls."[2] It is an important article, perhaps one of the most thorough treatments of the subject, and should be read by anyone interested in containing Medicaid costs.

Federal Requirements

States must implement a statewide surveillance and utilization control program which limits unnecessary and excessive payments and which promotes an effective, timely and appropriate use of services and facilities. Among other things, this program should permit post-payment reviews, either through random audits or through a review of services which penetrate a given cost or utilization screen. For example, the States should be able to analyze their programs using recipient utilization and provider service profiles. States should be able to flag certain behavior (e.g., if the number of injections per patient by a dermatologist in a given geographic region exceeds the norm for similar physicians by a given percent), and initiate a more detailed examination of specific recipients and providers. In short, States must monitor their plan and use and enforce "all corrective action to ensure the effectiveness of the program."[3]

The state Medicaid plan must set forth a continuous program for reviewing the utilization of covered care and services. Participating hospitals, SNFs and ICFs must have in effect, or be covered by, a written utilization review (UR) plan. Hospital UR plans, for example, must be established by the hospital-appointed UR committee. This committee is responsible for determining criteria for the need for admissions; the need for services which are costly, frequently "excessive" or unnecessary; or the services performed by questionable physicians. The hospital UR plan also must have procedures for admissions review, initial and continued stay review, and medical care evaluations.

A physician must certify an institutionalized recipient's need for inpatient care initially and recertify that need every 60 days. A written plan of care must be established and periodically evaluated and reviewed by a physician and other medical personnel for each inpatient recipient. The plan must be reviewed at least every 60 days in hospitals and SNFs and every 90 days in ICFs. The State must ensure that there is an annual medical review of SNF patients and an independent professional review of ICF patients.

Professional Standards Review Organizations (PSROs) are local organizations of physicians created by the 1972 amendments to the Social Security Act. While PSROs are administratively separate from Medicaid, they "have final decision-making authority on issues of necessity and quality of institutional care"[4] within the Medicaid program.* The PSRO relationship to the state Medicaid program is established in a Memorandum of Understanding (MOU) between the two organizations. However, the separation between the agency responsible for Medicaid expenditures and an organization (consisting of those being regulated) responsible for determining the necessity of medical services has created a number of problems. Perhaps the biggest concern has been the divergence of goals. While the States' primary concern was to use PSROs to control costs through the elimination of unneeded services, PSROs have largely viewed their mission as one of improving the quality of care.[5] In terms of the States' objectives, although a few PSROs throughout the nation appear to have "saved" enough money to cover their administrative costs, others have demonstrated a negative cost benefit relationship. In fact, a recent study by the Congressional Budget Office found that savings attributed to all PSROs represented less than 60 percent of the program's total costs.[6] A 1981 report by the General Accounting Office of 809 hospitalized patients concluded that, while PSROs denied payment for 1,779 of their hospital days, an additional 384 should also have been denied if the PSRO had acted in accordance with the relevant regulations and requirements.[7] The ineffectiveness of PSROs, therefore, is not directly related to the regulations per se, but to the assumptions that professionals would strictly regulate themselves and that separating the authority for determining medical necessity from the responsibility for paying for care would not severely compromise the cost containment goals. Not only have these assumptions been proved faulty, but they have produced duplication of efforts by the PSROs and

*The Omnibus Budget Reconciliation Act of 1981 (PL 97-35) eliminated mandatory PSRO purview over the Medicaid program. For a detailed explanation of the change in the law, see Appendix A.

the State, have frequently limited state intervention to only those areas not reviewed by PSROs and, in some instances, have forced States to monitor the effectiveness of the PSROs and press for the dissolution of certain PSROs.

While some States have been pleased with their relationship with their PSROs and the effectiveness of their PSROs, other States have not been as satisfied. Indeed, given the questionable effectiveness of many PSROs, many States have been penalized. They have been prevented from implementing their own review mechanisms and have been forced to abide by the medical and, therefore, expenditure decisions of often ineffective organizations. The best state response to this situation is to ensure that their PSROs are effective, operate according to federal standards, and have goals generally consistent with state goals. Selective monitoring of state PSROs is an essential function and one which can qualify for federal reimbursement.

New York has established an approach toward PSROs which should be carefully considered by other states. The state PSRO Monitoring Board, which has established specific criteria for determining medical necessity, conducts a systematic evaluation of each PSRO. These criteria are:

- disallowance of weekend admissions; i.e., hospital stays beginning on Fridays or Saturdays when procedures are scheduled for Mondays;
- limitations on preoperative days to one day unless justification is presented to and accepted by the PSRO;
- expedited preadmission review of all admissions for 11 elective procedures identified by the National Professional Standards Review Council;
- continued stay reviews in all cases three days after admission;
- required second opinions for overutilized or high-risk procedures; and
- a requirement that certain simple surgical procedures be performed only on an outpatient basis.[8]

When possible, each PSRO hospital is assessed relative to all other PSRO hospitals according to these criteria by reviewing retrospectively up to 20 percent of all Medicaid discharges. If there is a statistically significant difference between the number of PSRO days and the number that state monitors would have approved, the state initiates concurrent review for the next 90 days to validate its findings. If the results of the initial review are validated, the state can recommend to DHHS that it remove the PSRO's binding review authority for Medicaid.[9]

Developing an Effective Utilization Control Program

Because PSROs do not monitor all care and because a state should monitor its PSROs, state Medicaid programs must develop their own utilization control programs. Objective and operational definitions of unnecessary or inappropriate utilization are prerequisites to a utilization review (UR) program. These definitions set forth limits of acceptability, define the problem, and often indicate the most appropriate utilization control. The definitions must indicate whether:

- a procedure was medically necessary as indicated by local, regional or national norms and protocols or as defined by accepted experts;
- a procedure was delivered in the appropriate setting and with the appropriate intensity of resources; and
- a procedure falls within the realm of social priorities embodied in the program; e.g., cosmetic surgery for a burn victim may be justifiable while the same procedure for an aging, but vain recipient may not.[10]

These definitions will not only allow the State to select an appropriate control mechanism but permit it to define a target population and assess the effect of the control on this population. The control is designed to contain costs subject to predetermined quality constraints. Consequently, targeting should permit the State to maximize its

return on its administrative investment. Appropriate targeting requires, first, that the State limit its intervention, i.e., the utilization controls, to medical services which are amenable to control. For example, placing utilization controls on emergency care could seriously harm patients while placing controls on elective surgery would not have any deleterious effect on patients and, in fact, may save them the pain and trauma of unneeded surgery. Second, utilization controls should apply only to services which are frequently provided. Setting up special procedures for services which are rarely rendered is inefficient. Third, attention should be restricted to costly services. Monitoring frequently provided expensive services will usually result in larger savings than monitoring less expensive services (assuming that both have the same proportion of inappropriate usage). Finally, the focus should be on those services with a historic pattern of misuse.

In addition to being appropriately targeted, utilization controls must be enforceable. Enforcement requires unambiguous definitions of all prohibited actions, efficient and publicized systems for monitoring compliance, clearly delineated and nontrivial penalties and timely and consistent enforcement.[11]

One central element of any utilization control program is an effective automated data processing system which is programmed to develop an appropriate data base, i.e., relevant profiling of providers, recipients and/or services. The federal government has developed standards for such a system and has labeled it the Medicaid Management Information System (MMIS). The Surveillance and Utilization Review (SUR) component of MMIS is specifically designed to permit the State to monitor patient and provider utilization behavior. Without MMIS, utilization controls cannot be properly employed, monitored or adjusted. Legislation adopted in 1980 imposes penalties on States that do not have an operational MMIS system by late 1982. While many small States (i.e., those under one million people or less than $100 million in Medicaid expenditures) are exempt from the new law, those States without the resources to implement and maintain an automated data processing system like MMIS should consider forming a consortium with surrounding States and sharing services.[12]

Financial Disincentives

Requiring patients to make payments to complement program coverage serves as a disincentive to the inappropriate utilization of services. There are three types of financial disincentives: 1) deductibles or a fixed first dollar amount which must be paid by the beneficiary before the insurance becomes effective; 2) coinsurance or a percentage of the bill paid by the beneficiary; and 3) copayments or a small payment which must be paid each time a specific service is rendered. Currently, States may not make extensive use of these mechanisms. Federal law, for example, prohibits copayments on mandatory Medicaid services for the categorically eligible recipient. Nevertheless, three States currently have waivers from that prohibition. Copayments are allowed for optional services. Requiring copayments of an indigent population must be viewed in terms of what the State wishes to accomplish. Specifically, a copayment is useful if it dissuades a patient from making medically unnecessary demands on the system but does not interfere with physician-directed therapy. Using these criteria, it would be unreasonable to impose a copayment requirement on inpatient hospitalization, long-term care, pharmaceuticals, medical supplies or devices. Hospitalization or placement in a long-term care facility is a medical decision made by the physician, not the patient. Further, institutionalization can be more effectively restrained by other utilization controls. Drugs, medical supplies and devices also are physician decisions, and a good deal less expensive than if the financial disincentives convince a patient to defer taking his medication and lead to his hospitalization. Further, if specific drugs or devices are of questionable efficacy, they should not be included

as a Medicaid benefit.* There are, however, more effective mechanisms for controlling excessive use of drugs (e.g., a lock-in program**).

The most sensible approach to copayment is to apply it to those medical decisions normally made by consumers; that is, decisions to seek care from a physician or physician substitute (podiatrists, chiropractors, outpatient departments or clinics). Copayments force the patients to evaluate their needs more carefully and encourage physicians to be more responsive to those needs. The choice of whether or not to continue seeing a specific physician in a given setting is not merely one of choosing to receive one part of therapy, but all therapy under the direction of that doctor. The State should exclude all medical services for chronic conditions from copayments since a patient's choice is more constrained and lack of care may lead to institutionalization and irreparable harm. Nor should copayments be required for services which are preventive, of proven effectiveness and socially desirable (e.g., prenatal and infant care), or for emergencies. States also may use copayments to discriminate among care settings, as Michigan is attempting to do, by requiring beneficiary copayments only for the nonemergency use of emergency rooms.[13] Copayments, however, do have several drawbacks. The utility of copayments rests with the assumption that the patient can make rational decisions between options, and can weigh trade-offs. The pressures of poverty may preclude such rationality and could make copayments simply a punitive device. Current regulations limit copayments to nominal amounts and, therefore, any appreciable savings would be derived from deferred services, not the copayments themselves. Finally, copayments for physician services would require a federal waiver.

Patient-Provider Education

States can also initiate education programs to reduce Medicaid costs. During the initial contacts between the recipient and the social worker, the costs of alternative forms of care should be reviewed with the recipient.[14] States can compile regional directories of physicians and dentists who participate in Medicaid, indicating specialties, hours and selected rates.[15] Special programs can be designed for educating patients with high utilization and/or expenditure rates. For example, Texas screens recipients who annually exceed 25 physician visits, whether office or hospital outpatient visits, or a combination of 25 office and outpatient visits; who visit six or more physicians; or who utilize $1,500 or more in total dollar volume (excluding surgery and inpatient charges). The records for these individuals are discussed with them. If it is determined by a nurse that there is overutilization, the patient is enrolled in an education-counseling program which he must attend to receive an eligibility card. The extent and proper use of Medicaid benefits are reviewed with the patient and problems are discussed. The counseling ends when the client understands the proper use of the program. No penalties or lock-ins are tied to this effort, but Texas still estimates a five-dollar return for every dollar invested.[16]

States should also formulate education programs for providers with high utilization and expenditure rates. Utah employs a Physician Ambulatory Care Evaluation (PACE) program. This program identifies questionable behavior in terms of specific guidelines (i.e., abdominal X-rays during pregnancy, Lomotil for children under two, and tonsillectomy and adenoidectomy without appropriate indications). The MMIS system and PSRO data are used to identify questionable physician practices. PSROs then review the physician and patient profiles. When physician behavior seems inappropriate and remains

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* The Omnibus Reconciliation Act of 1981 does prohibit federal payments for drugs determined by the Secretary of DHHS to be less than effective.

**A lock-in program restricts individuals who over-utilize or misuse Medicaid services to one physician and, frequently, to one pharmacist. This prevents excessive doctor-shopping and inordinate purchases of drugs. The Omnibus Reconciliation Act of 1981 provides statutory authority to states to restrict to particular providers those individuals found to be overutilizing Medicaid services.

unaltered despite PSRO contacts, the PSRO sends claims back to the State "without endorsement," an action normally resulting in nonpayment. Cases can also be referred to the State for investigation.[17]

States could also schedule meetings frequently with provider associations and individual providers to discuss Medicaid policies and problems. Regular contacts provide a useful forum to review and explain utilization controls. Provider newsletters announcing and explaining regulations, reviewing conferences, etc., should also be used.

States should monitor the effectiveness of the discharge and planning units in all high-volume Medicaid hospitals as well.[18] If those units are not operating effectively, the State should initiate intensive educational programs to describe the problems and suggest solutions. If unsatisfactory performance persists after a reasonable period, the State could discontinue paying any of the associated costs.

Review Mechanisms

Review mechanisms require physicians and/or nurses to carefully review the patient's medical condition before a service is rendered. The final determination of necessity, however, is left up to the individual recipient or provider.

One form of review is the Pre-Admission Test (PAT), which is designed to ensure that hospitalization is necessary prior to admission. The review is normally done by professional peers. The technique has been applied with mixed success. For example, the experience of the Genesee Medical Corporation in Michigan, the United Auto Workers (UAW) and the Big Three auto manufacturers indicates that there was a 20 percent reduction in the length of stay for those cases reviewed. On the other hand, when PAT was used by Blue Cross of Western Pennsylvania, 99 percent of PAT patients underwent surgery, and the preoperative length of stay was unaffected.[19]

Second Consultations are another review procedure requiring patients to receive the advice of a second physician prior to undergoing surgery for (all or selected) elective operations. The patient is not required to accept the advice of the second physician, and the consulting specialist is usually not allowed to treat the patient. Second consultations became popular with the publication of a study of two New York unions which required that members receive the advice of a second physician before reimbursement for elective surgery would be approved. Nonconfirmation was generally higher than expected, particularly for services such as hysterectomies, D&Cs, and prostate surgery.[20] The program was considered a success. However, as Bruce Stuart notes, the applicability of a mandatory second opinion program to Medicaid requires that the following factors be in place.[21] First, there must be an adequate and accessable supply of consulting specialists. Second, the State should limit elective surgical procedures requiring second opinions; specifically, those frequently-provided services for which high rates of nonconfirmation are expected. Third, the State must monitor any change in rates of nonconfirmation over time. Finally, there should be an incentive for patients to make the program work.

Second consultations have been discussed as an important control mechanism for public programs for several years. Recently, Massachusetts implemented mandatory second consultations for its Medicaid recipients for the following services: Tonsillectomy and/or Adenoidectomy; Hemorrhoidectomy; Cholecystectomy; Hysterectomy; Disc Surgery/Spinal Fusion; Joint Cartilage Surgery/Meniscectomy; Submucosa Resection/Rhinoplasty/Repair of Nasal Septum; and Excision of Varicose Veins. Michigan recently adopted a similar program. Both Massachusetts and Michigan have experienced about a 20 percent reduction in the incidence of covered surgical procedures.[22]

A third kind of review procedure involves certification and recertification. "Certification" procedures require physicians to provide written affirmation that their Medicaid patients who are hospitalized or placed in a nursing home require institutionalized care and special services. "Recertification" is a periodic reaffirmation by the

physician that the patient continues to need institutional care. In and of themselves, certifications have not been a major component of any State's cost containment strategy, but they may be particularly useful in addressing the problem of routine testing of all hospital patients. Hospitals frequently perform standard preoperative lab and X-ray tests without a direct request from the physician or determining if the physician had performed similar tests. To avoid duplicate or unneeded tests, all lab and X-ray services should require the certification of the ordering physician.[23] Of course, the most effective way to control this type of behavior would be to adopt Michigan's policy of not recognizing routine testing and requiring that preadmission testing be done on an outpatient basis.

A fourth kind of review mechanism is prior authorization, which is similar to PAT and second consultations. Prior authorization reviews the need for a service prior to the delivery of the service. Prior authorization, however, goes one step further and involves a state appointed and/or operative review team which can deny payment for the services. In short, the State acts as the final arbiter of necessity. This is potentially a much stronger and more effective method of controlling utilization than PATs or second consultations.

Federal regulations require any State using prior authorization to:

- "establish guidelines to be used by personnel to whom the prior authorization function is assigned and make the guidelines available to providers; there must be an adequate number of qualified personnel to process requests for prior authorizations so that needed services are not unnecessarily delayed";
- instruct providers that "requests for prior authorization should include sufficient factual data to enable a fair and objective decision";
- inform recipients of the purpose of prior authorization and of their "right to a fair hearing with respect to any request rejected, modified, or unduly delayed by" the State;
- assure that needed services are not unduly delayed "by onerous paperwork and time-consuming procedures";
- "not apply to situations where the cost of administration could exceed or equal the cost of the service or material to be provided"; and
- "not interfere with the recipient's right to free choice of providers."[24]

Prior authorization can be applied to a variety of services, such as elective surgery, medical supplies and devices, and various forms of therapy. Elective surgery is a likely target since it represents one of the most expensive components of health care and since it is frequently overused. If a state chooses to require prior authorization for elective surgery, it should consider including the services and procedures identified as dubious by the National Association of Blue Shield Medical Necessity Program and the 11 questionable procedures identified by the National PSRO Board.

California has one of the most extensive prior authorization programs. Referred to as Treatment Authorization Requests, or TARS, Medi-Cal requires TARS for elective hospital admissions, specific physician office visits, assistive devices, hearing aids, psychiatry, physical, speech and occupational therapy, home health, dialysis, and transportation.[25] While some have argued that Medi-Cal could have increased its effectiveness and the return on its administrative dollar by focusing only on the very expensive procedures, California claims to have realized a savings of $12.6 million to $18.8 million in benefits for hospital admissions, and $12.7 million for other medical services (e.g., physicians, psychiatrists, and medical transportation) in 1978. The ratio of savings to administrative costs was extremely high.[26]

Authorization requirements are generally directed toward services which are costly, frequently used or risky. However, it may be necessary to control, regulate or sanction individual recipients and providers on an ongoing basis. To do this, States must establish standards and protocols which objectively define abuse. Only after the State has the capacity to identify abusive behavior and the ability to quickly and easily intervene can it prevent certain individuals from continually behaving in an unacceptable fashion. Two

components of the MMIS are specifically designed to help the States achieve these objectives; viz., the Surveillance and Utilization Reporting System (SURS) and the Management and Administrative Reporting System (MARS). Once the State has established the appropriate protocol and incorporated standards into an operational MMIS, it can facilitate further intervention by exempting Medicaid fraud and abuse from the State Administrative Procedures Act.[27] States can also restructure Medicaid contracts with providers to allow participation only for a limited time. This would permit the state to review contracts periodically and terminate relationships with providers who have a history of abuse. In Minnesota, it has been suggested that such contracts should also allow the state to review all records relevant to the conduct of the vendor, and should specify that if requested records are not made available within a reasonable time, claims will be rejected. It was also suggested that contracts require providers to agree to permit the state to debit their accounts when improper billing is documented.[28] In California, the provider contract is being considered as a means for restructuring the Medi-Cal program. Two of California's requirements might be considered by other States. California's contracts carry a legal obligation to serve Medicaid clients and to provide services which meet explicit quality standards. Failure to meet either condition could result in expulsion from the Medicaid program.[29]

When recipients use physicians, outpatient departments or drugs excessively, and when the State is unable to document the medical necessity for those services, States can request prior authorization for all visits or purchases beyond a specified limit. A more stringent action is to "lock" the recipient into one physician and one pharmacist. This action eliminates doctor-shopping and reduces the likelihood that recipients will be able to purchase excessive amounts of drugs. For example, the Missouri lock-in program identifies lock-in recipients through a two-stage process. First, the MMIS flags any individual who in one calendar quarter uses:

- four or more physicians;
- seventy-five or more physician or other professional services;
- four or more pharmacists;
- seventy-five or more prescriptions; or
- two or more hospitals for inpatient care.

Before contacting individuals identified, the State:

- reviews the medical history with a state physician or pharmacy consultant to determine if the utilization pattern was justified by the diagnosis shown on the profiles;
- reviews the entire claims history of the recipient, which the computer also can generate, to see whether the pattern was a logical outcome of a long course of therapy;
- examines the provider's history; and
- contacts the recipient's caseworker to gather other information that might explain the patient's behavior.

If a recipient's behavior remains medically unjustifiable, he is contacted by his caseworker, after which he is "locked into" or allowed to use only one physician and one pharmacist. The Medicaid ID cards for these recipients indicate that the client has been assigned to specific providers and that services rendered by unauthorized providers will not be paid. Missouri currently has 6,000 recipients locked in and estimates a minimum total savings of $1.82 million a year.[30]

States can institute provider lock-ins as well. Whenever a provider demonstrates excessive or unjustifiable behavior he can be locked into a prior authorization program tailored specifically to prevent unacceptable practices. The State also can consider

*In addition to providing statutory authority to the States to "lock in" recipients abusing the system, the Reconciliation Act of 1981 authorizes States to limit or suspend from participation in the program providers who render either medically unnecessary services or services which are professionally substandard.

postdelivery denial of payment for all or specific instances of unnecessary care. Further, Medicaid agencies, in cooperation with the State licensing boards and the state medical societies, may establish tribunals to adjudicate instances of fraud and abuse.

Whatever administrative sanctions are applied, the State should establish a well-defined system of civil and criminal penalties. These laws should state that any provider or recipient convicted of fraud will be suspended or permanently barred from participating in the Medicaid program.

In addition, States could consider automatically suspending or permanently revoking the license of any provider convicted of fraud. The primary effect of these penalties would be to deter fraudulent behavior. The current deterrent effect, however, is probably significant and justifies the continuation of fraud units. Increasing the penalty to include expulsion would improve it further. Antifraud actions, however, have not proved to be efficient in recovering misspent funds. Indeed, a recent GAO study of seven state Medicaid fraud units found that between 1978-1979 these units identified potential recoveries of $19 million at total operating costs of $39 million.[31] Thus, without considering their deterrent effect, fraud units yield fifty cents on each dollar invested in them.

CHAPTER IV

RESTRUCTURING DELIVERY OF SERVICES

Medicaid program policies can be designed to establish incentives to provide care in appropriate but less costly settings. This goal requires a two-pronged approach. First, States must attempt to eliminate inappropriate use of costly institutional settings. Second, States must increase the ease with which providers can offer appropriate and less costly care while improving the client's access to providers. These goals are more easily stated than achieved.

Limiting Access to Institutions

Eliminating inappropriate use of hospitals and nursing homes is a critical component of a successful cost containment program. The goal can be accomplished by: 1) constraining the available supply of beds through the certification process; 2) structuring reimbursement systems to encourage the delivery of services in the proper setting; 3) designing an aggressive utilization review program consisting of controls discussed in the previous section; and 4) some combination of case management and gatekeeping.*

Several techniques can be used to limit the supply of Medicaid beds. First, the number of beds certified for the program could be considerably less than the number of licensed beds. Kentucky and Mississippi, for example, recently reduced the number of beds certified for their Medicaid programs.[1] Certification limitations could be based on qualitative standards or some desired geographical distribution of beds. Limiting certification, however, would require that a number of problems be worked out in advance. For example, what would happen if a private nursing home patient exhausted his funds and became eligible for Medicaid but all the Medicaid-certified beds in his community were filled? Would this approach require comprehensive screening for all nursing home patients? Would new state legislation be needed?

Services for specific specialized tertiary care services and/or obstetric care services could be limited to specific hospitals. This would increase occupancy levels at those hospitals and, therefore, cut the average cost per patient for Medicaid. It would also allow Medicaid to monitor more fully the care its clients receive.[2] A federal waiver would be needed to implement this strategy.

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*The Omnibus Reconciliation Act of 1981 has provided perhaps a fifth option by extending waiver authority to the Secretary of DHHS to permit states to restrict a recipient's "freedom of choice" as to the provider who shall render the particular service that is needed. For a more detailed description of this change in law, see Appendix A.

States may be permitted to adopt a "swing bed" policy for individuals in acute beds but in need of nursing home care only. A swing bed policy permits a hospital to designate a number of its beds as either acute or nursing home depending upon the patient's medical status. Currently, several States have swing bed policies in effect under a waiver demonstration from DHHS. Reimbursement rates for the swing bed when it provides long-term care could be set at a rate not to exceed the maximum rate permitted in free-standing nursing homes, or a percentage of the acute care cost, or a rate resulting from a more narrowly defined set of allowable costs. Before implementing such a strategy, States should determine if potential benefits are equal across hospitals regardless of size and geography. It may be, for example, that the swing bed policy is more suitable to rural areas where access to nursing home beds is even more limited than to hospital beds, or to urban areas that have excess hospital beds. The 1980 Reconciliation Act permits rural hospitals with less than 50 beds and a certificate of need to provide long-term care to use swing beds. Demonstration projects for other hospitals, however, are allowed under the Act.[3]

Administrative days in a hospital are days when a patient could be placed in a nursing home or some other setting, but placement is not done due to lack of availability or access. There are three ways to remedy this situation. First, as a result of changes in federal law in 1980, States must pay administrative days at the maximum rate permitted in the lowest cost appropriate setting. Moreover, States could consider limiting the number of administrative days it will pay per patient stay.[4] Or, States could adopt policies to decertify permanently beds in hospitals in which administrative days are excessive. A trigger mechanism could be established, for example, which would downgrade hospital beds to SNF beds if a given proportion of the hospital's total bed days (e.g., 5 percent) were administrative. New York has statutory authority to decertify beds for long-term rather than acute care use. In fact, New York is currently considering decertification of a large proportion of beds in an upstate hospital where a number of patients would be more appropriately placed in a nursing home. The major concern is that patients are not receiving the care they need in a hospital setting.[5]

Reimbursement Incentives

Rates and fees should be set to encourage the provision of care in the least expensive, but appropriate, site. For example, Michigan established differential physician fee screens that are higher for an outpatient than for an inpatient setting for procedures that can be safely performed on either basis.[6]

Another approach would be to set an all-inclusive rate schedule for hospital services which ranks services by level of hospital (primary, secondary or tertiary), and then applies a rate that an efficient (or average) hospital within the appropriate group would charge for the service. Such a methodology would also require that services identified as tertiary be provided by tertiary care hospitals only and that secondary care services be provided by tertiary and secondary care hospitals. Primary care services could be provided by all hospitals. This approach would prevent hospitals ill-equipped to deal with complex cases from providing those services in order to receive premium reimbursement. On the other hand, if a tertiary care institution can offer services at rates equal to or lower than less complex facilities, then it should be allowed to do so. Thus, open heart surgery might be limited to tertiary care institutions and the rate paid to those hospitals would be based on an average cost across tertiary care institutions. A simple appendectomy, however, would be reimbursed at the average cost experienced by primary care hospitals. This methodology, however, is extremely complicated. It requires that all hospitals be designated as tertiary, secondary or primary, and that all services be categorized and costed out within the appropriate institution.[7] Recent changes in federal law would permit States to implement this approach.

States can also use reimbursement to limit the use of hospital care in a much more sophisticated and sensitive manner than the customary limitation in total hospital days. Hospital reimbursement, for example, could be limited to the 75th percentile of the length of stay (LOS) by diagnosis. The percentile selected is arbitrary; it could be higher or lower. Reimbursement would not be made for hospital days in excess of the LOS limit, and exceptions would only be granted with state approval. Setting reimbursement limits by LOS might be restricted to only those diagnostic areas or admissions not reviewed by the PSRO. The State could argue, as New York has, that setting LOS limitations is a function well within the jurisdiction of the state Medicaid program and not in conflict with the PSRO's determinations. According to the New York Office of Health Systems Management, New York (and presumably other States) is justified in constraining reimbursement by a LOS limit on the grounds that:

- The PSRO disallowance is based on a concurrent review of individual cases while the LOS standard is a component of the overall reimbursement method designed to establish a per diem rate of payment that represents an efficient production of service;
- The PSRO activity is not intended to cover all cases while the LOS standard functions as an overall operating efficiency measure;
- The PSRO disallowance is primarily related to lack of medical record documentation to demonstrate that appropriate care was rendered;
- The PSRO is not typically concerned with discharge planning efforts once a patient has entered an alternate care status. As such, the PSRO activity is not necessarily consistent with a measure of excess LOS.[8]

However, restrictions on reimbursement that differentiate between diagnostic categories may require a federal waiver.

As noted above, utilization controls become even more important under conditions of scarcity, not so much to prevent unnecessary care as to assure that those most in need of care receive it. Prior authorization becomes a critical part of this process.

Utilization controls by themselves, however, are insufficient to prevent inappropriate utilization of institutional services. It is necessary, therefore, to provide mechanisms which go beyond indicating whether someone should receive (or continue to receive) a service to mechanisms which accept or redirect a patient to an alternative setting, i.e., gatekeeping, or which would coordinate and direct all of the services a patient needs, i.e., case management.

Gatekeeping, for example, might be very suitable for addressing the use of emergency rooms as ambulatory clinics. In high-volume Medicaid hospitals—usually public hospitals or inner-city private teaching institutions—a disproportionate amount of the care rendered in the emergency room could have been provided elsewhere. A 1970 assessment of Philadelphia General Hospital revealed that 90 percent of the emergency room visits were "diagnosed as everyday medical problems such as influenza, gastrointestinal upset and superficial infection."[9] In major Cleveland hospitals serving the poor, 50 to 70 percent of the emergency room visits are for nonemergencies, even though both the city and the county operate outstanding ambulatory clinics which are free to the poor (in fact, because of passive bill collecting practices, they are essentially free to anyone) *and* which are underutilized.[10] Lack of available alternatives is clearly not the only reason that the poor use hospital emergency rooms. The poor seem to feel that the emergency room is where they are "supposed to go" and they are accustomed to it.[11] However, using emergency rooms is not only an expensive custom but also one which discourages follow-up care or continuity of care. States can address this situation by employing personnel to screen emergency room patients in high-volume Medicaid hospitals or by developing appropriate criteria for hospitals to distinguish emergencies from nonemergencies. States could reimburse nonemergency ambulatory care at levels no higher than the rates paid to free-standing clinics and/or physicians in their offices.

It must be stressed that, if nonhospital based services are not made available prior to the rate reduction, the net result will be the denial of care. States must also ensure that alternative ambulatory care sites are available. Other options would include hiring physicians and setting up offices, subsidizing local public clinics or contracting out to private physicians. According to the Health Services Administration, the availability of primary care centers has produced dramatic reductions in both emergency room use and inpatient hospitalization.[12] In any event, policies that redirect or restrict access will probably be challenged by clients in the courts and States must be able to demonstrate that this policy is not punitive.

Gatekeeping should be applied as vigorously to nursing homes as to hospitals because most States spend more on nursing home care than on hospital care and because the admissions practices in many homes may require public regulation or review. Because most States do not reimburse nursing homes according to the services they provide to individual patients, nursing homes have a strong incentive to admit the least troublesome, least costly and healthiest Medicaid patients requesting the nursing homes' services. These patients pose the least financial risk and produce the greatest profit. It should be stressed that, as the supply of beds is increasingly constrained through certificate of need authority or decertification of Medicaid beds, nursing homes have a greater ability to choose who they will accept, to "cream-skim," by denying access to those patients in greatest need of nursing home services.

Clearly, from the States' perspectives, those who should be institutionalized are the more sickly, infirm and costly-to-care-for clients. Gatekeeping, in the form of preadmission screening, appears to be very effective for enforcing this state preference. A recent GAO study identified two general models for gatekeeping,[13] differentiated primarily by reimbursement authority. The first model involves review of the patient, denial of nursing home payment if such care is not required, and approval of payment for required noninstitutional services. The second approach does not involve public reimbursement decisions, but is limited to designing and arranging for community based services whenever a patient can possibly be diverted from entering a nursing home. The most persuasive model, of course, is that which is tied to the reimbursement system. Virginia and New York offer two excellent examples of how gatekeeping programs might be implemented.[14]

In Virginia an attempt is made to screen all potential long-term nursing home patients—both public and private. All Medicaid clients and all private patients who might become eligible for Medicaid within 90 days of admission are screened before they enter the home. If a private patient refuses to be screened, the state will not pay for that individual if he becomes impoverished and potentially eligible for Medicaid. This is an eminently sensible policy since many private nursing home patients deplete their savings and resources and become Medicaid recipients. A Congressional Budget Office study estimated that in 1974, 47.5 percent of Medicaid's nursing home patients initially entered the home as private patients.[15]

The screening in Virginia is performed by an interdisciplinary committee of the local health department. If it is determined that the individual can be cared for in the community, services are arranged, and nursing home admission is not authorized (i.e., payment is refused). During the first 10 months of operation in 1977 Virginia assessed 1,755 individuals, found that 395 could remain in the community, and saved an estimated $1.6 million.[16] During a more recent 21-month period, 21 percent of the individuals screened were diverted away from nursing homes.[17]

In a similar but more complex effort, New York in 1977 initiated the "Nursing Home Without Walls Program," which offers a comprehensive and coordinated set of services through certified home health care providers. Providers offer a broader range of services than the state normally provides, and services are available 24 hours a day, 7 days a week,

for patients in their homes. Medicaid eligibles can receive these services only if they would otherwise be placed in an ICF and if "the total cost of health care services provided to maintain a patient at home [is] no more than 75 percent of the average Medicaid cost of maintaining a patient at the comparable care level in an ICF."[18] As of July 1981 the program had served 649 patients. The average monthly budget of all patients was $968 for SNF patients and $637 for ICF patients—50 percent below the average monthly SNF rate of $1,956 and the average ICF rate of $1,238. The State estimates an average monthly savings of $988 per SNF patient and $601 per ICF patient if the patient would otherwise have entered a long-term care facility.[19]

The ultimate success of either the Virginia or the New York approach will depend on: 1) the development of a sufficient amount of alternative services; 2) design and application of a satisfactory protocol which not only determines who needs nursing home care and who needs noninstitutional services but also imposes absolute limits on the number of clients receiving either set of services; 3) the presence of appropriate agencies to coordinate the services; 4) the State's ability to monitor those agencies; and, 5) the availability of adequate state funding.

Limiting access to costly settings cannot be pursued as a goal in and of itself. The goal is to have effective services delivered in the least expensive setting, and to do this States must increase access to less costly services. States can assist in expanding the supply of noninstitutional providers, improving reimbursement procedures and relying on gatekeeping and case management. Utilization controls are not easily applied to noninstitutional settings. While the Medicaid program should be able to identify egregious misuse of physicians—as is done, for example, with the Missouri lock-in program—broad application of utilization controls to ambulatory care would be difficult and generally not cost-effective, given the relatively low cost of the services, the dispersion of provider sites, and the cost of monitoring care.

Reimbursement rates for physicians and other practitioners should be reviewed and increased where necessary. Some States, for example, have not increased their physicians' fees for nearly 10 years. The net result, of course, is to discourage physician participation and force clients into clinics and hospitals for ambulatory care. Medicare policy now formally recognizes a disparity between physician inpatient and outpatient rates for services that could be safely performed on an outpatient basis. Subject to certain conditions, the Omnibus Reconciliation Act of 1980 requires that a physician willing to accept assignment under Medicare be reimbursed 100 percent of the reasonable charge for performing approved procedures in a free-standing ambulatory surgical center, a hospital outpatient department, or his office. For those procedures which can be performed in a physician's office, reimbursement would also include a standard amount for overhead expenses.[20]

Community-Based Long-Term Care

About 88 percent of those between 18 and 64 who are functionally disabled and 70 percent of those over 65 who are disabled receive their care through family members and friends.[21] The State should strive to complement informal care by providing services which support it or by reimbursing individuals rendering such care. For example, children often place a parent in a nursing home when he or she becomes incontinent. Incontinence clinics, such as the one being established in Cleveland, Ohio, could be sponsored by the State. These clinics show family members how to deal with the incontinent parent and how to minimize or cure the condition.[22] Another example would be respite care programs which give relatives caring for Medicaid recipients periodic breaks from those responsibilities, while the state cares for those infirm clients for a few days. New York recently enacted a law (S 4988-B) authorizing a number of demonstration projects to determine the effectiveness of respite care in allowing family members to maintain a normal routine and in deterring requests for long-term institutional placement.

Another effort to promote more informal care is exemplified by recent legislation adopted in Idaho. The new law (HB 173) allows a $1,000 tax deduction to individuals for each immediate relative 65 or older who is maintained in the household.

Several other approaches to informal care should be mentioned. In Boston a demonstration project with a telephone system called Life Line proved to be very successful. Frail and infirm residents of a public housing project were tied into a telephone system which, at the press of a button, sent emergency assistance to the individual's apartment. The system also had a passive alert component. If a telephone had not been used or reset within a 24-hour period, the individual would be contacted by Life Line personnel to check on their well-being.[23] In Seattle, a project is underway which helps isolated elderly individuals living in the community find someone compatible to live with who can share costs, break the isolation and provide mutual support.[24]

States can also pay for informal care. Oklahoma developed a "Non-Technical Medical Care in Own Home" program as part of its Medicaid system. Under the Oklahoma plan 3,000 friends and neighbors, after receiving training and working under the plan of a physician and the guidance of a nurse, have rendered nontechnical care—preparation of meals, assistance with daily living, providing simple occupational therapy—to Medicaid recipients in their homes. The state paid the nontechnical provider a nominal rate—$6.37 a day for the first person in the home and $3.19 for each additional person—in 1976. The client avoids being placed in a nursing home and the State avoids the cost of institutionalization.[25]

Encouraging Less Expensive Care

States could expand their use of lower cost options by carefully reviewing their policies on the use, licensing, and reimbursement of physician assistants (PAs) and extended-role nurses. If a State reimburses PA services at a percentage of the physician's fee (e.g., 80 percent), it may realize immediate savings for the services which are delivered. Even if a State reimburses PAs at the same rate as physicians, savings may accrue from increasing access to a lower cost alternative; that is, a physician office visit is less costly than a hospital outpatient clinic or an emergency room visit. This tactic assumes that physicians would be willing to employ the PAs at the reduced rate; that the cost of the expanded ambulatory services does not exceed the "savings" accrued because more expensive services were not consumed; and that increased access to ambulatory care reduces institutionalization.

In health manpower shortage areas, the state can directly or indirectly (through community organizations) open ambulatory clinics to serve the poor. Where feasible, National Health Service Corps personnel could be used to reduce state costs. These clinics could be based in public hospitals or in existing public agencies.

If States attempt to control costs by only expanding access to noninstitutional care, the likelihood is great that an increase in total program expenditures will result. This is due to the enormous excess demand for both expensive and inexpensive services, and the often low level of substitution between them. According to William Weissert,[26] this reasoning is particularly appropriate to nursing homes and the whole range of services which fall under the generic label of "alternatives to long-term care": adult day care, homemaker services, meals-on-wheels, protective services, etc. For a long time federal and state administrators have believed that a large proportion of the patients in nursing homes were inappropriately placed and that if alternative services had existed these people would have remained in their own homes.[27] Implicit in the argument was the belief that nursing homes could be emptied of up to 75 percent of their patients, that these patients could return to the community and a better life, and that the State would save money. Weissert has shown that empirical work in the field does not corroborate these beliefs. Neither adult day care nor homemaker services seem to affect whether an individual will

go into a nursing home or, once there, how long he will stay.[28] Day care appears to have no significant impact on death rates or physical, mental or social well-being. And, as Weissert concludes, the cost implications are significant. "Most patients (79 percent) used day care as an add-on to existing services, rather than as a substitute for nursing homes. This tended to raise costs considerably rather than to lower them because nursing home rates did not go down, while day care costs were added. Put another way, $637,631 was spent on day care to prevent $37,397 in nursing home costs."[29]

There are three problems associated with the alternatives: 1) the use of nursing homes is generally low among the elderly population; 2) average lengths of stay tend to be shorter than a "long-term" institution would suggest—one-third of all admissions are discharged within a month; more than half, within three months; 3) there are indications that there may be twice as many bedfast and housebound elderly in their own homes as there are in institutions. Thus, it is difficult to devise alternatives which are cost effective, given the low rate of nursing home use, relatively short lengths of stay, and the extension of the noninstitutional benefit to the entire eligible population.

Weissert's arguments notwithstanding, gatekeeping and case management are very important methods for allocating long-term care services. Not all of the eligible population can or should have access to the full range of services. Someone must be responsible for matching clients with the appropriate services within a predefined and limited budget. Several experiments throughout the country are doing just this. In addition to New York and Virginia, there is the Connecticut Triage project, Georgia's Alternative Health Project, and federal channeling grants, a national experiment ongoing in several States established to test the design and applicability of various case management approaches to long-term care.

In the end, it may be that the only way to limit costs under existing policy is to limit the number of nursing home beds, limit the funds allocated to community-based services, assure that services are, in fact, provided, and assess the impact on Medicaid clients.

If existing long-term care policies "in toto" were challenged and if States were able to overhaul their entire long-term care systems, then how might States approach their current problems? In Bruce Vladeck's book Unloving Care this issue is explored and a blueprint for change is presented. Vladeck argues strongly and cogently that the most reasonable solution to the problems posed by nursing homes would be to "limit nursing home admissions to the moderately-to-severely disabled; rank nursing homes by quality and close low-quality homes; develop congregate housing in existing buildings; and develop and manage gatekeeping agencies."[30] While Vladeck recommends that these changes be made on a national basis, States might consider this approach on a smaller scale.

As more global changes are made for long-term care or hospitalization or the entire range of available health services, conventional fine-tuning of the reimbursement and financing arrangements becomes insufficient. Broad alternatives must be considered.

Alternative Financing Structures—Comprehensive Prepaid Strategies

Most Medicaid cost containment strategies compensate for, or attempt to counter, incentives to health care providers to increase the use and cost of services. Many cost-reduction initiatives, such as increased program oversight, provider reporting requirements and reduced fee schedules, make providers more reluctant to participate in the Medicaid program, thus compromising client access to care and, in some cases, actually increasing costs because clients may have to seek ambulatory care from costly hospital emergency rooms.

Instead, Medicaid programs can pursue medical care financing structures that make providers accountable for costs and establish positive incentives for providers to use health resources economically and to provide care in the most cost effective, appropriate setting. The most recognizable name associated with such alternative financing structures is health maintenance organizations, or HMOs. These are organizations which charge a fixed fee per individual enrolled (a capitation rate) and assume responsibility for providing a broad array of services. HMOs survive and flourish if they can attract members and operate within their fixed budgets. HMOs tend to experience consumer satisfaction equal to the fee-for-service delivery system, have lower hospitalization rates, and lower total per capita expenditures.

In the early 1970s the federal government endorsed and encouraged state Medicaid programs to use HMOs. If Medicaid clients could be transferred to HMOs, it was argued, then the State would be able to budget program expenditures more effectively and accurately; simplify program management; eliminate fraudulent and abusive practices directly linked with fee-for-service (e.g., billing for undelivered services or providing unnecessary care); extend comprehensive mainstream medicine to welfare recipients; and, most important, contain costs. These arguments led to a flurry of HMO activity in several major States. Between 1971 and 1973 Medicaid HMO contracts nationally jumped from 4 to 66 and total HMO Medicaid enrollment climbed to 371,000.[31] California was the most active State. By 1973 the State had enrolled 247,000 Medi-Cal clients in 55 prepaid health plans (PHPs.)[32] Many of these PHPs served Medi-Cal clients exclusively. As this PHP activity peaked, a series of state and federal investigations in California reported a series of program irregularities. Inappropriate and fraudulent marketing practices were common. For example, clients were told that their Medicaid coverage would lapse unless they enrolled, benefits were exaggerated and recipients were told that they could no longer use their old physician or pharmacist. There were indications of gross underutilization of services. One study showed that Medi-Cal recipients in HMOs experienced 36 percent as many hospital days and 15 percent as many nursing home days as their Medi-Cal counterparts in the fee-for-service system.[33] Horror stories were reported concerning denials of emergency care and poor treatment.[34] Finally, there were indications of excessive administrative costs: more than half of the $56 million paid to 15 Medi-Cal PHPs went toward administrative expenses and profits.[35] All of this led to tighter legislation and administrative practices. In 1977 there were only 18 HMOs with Medi-Cal contracts serving 150,000 clients.[36] By 1980 the number of participating HMOs had dropped to 12 and enrollees to 111,000.[37]

The early California experience does not mean that HMOs are not a desirable alternative. It does mean, however, that when an HMO consists primarily of Medicaid recipients, it will behave differently than theory suggests and will require different regulations and controls. This occurs, in part, because Medicaid recipients differ from the middle class enrollees whose behavior serves as a basis for the HMO model; that is, the HMO model assumes an informed, assertive consumer who realizes a monetary saving by joining the HMO, is willing and capable of demanding services, and will disenroll if unsatisfied with the care. Medicaid enrollees, on the other hand, do not pay for their care and, therefore, do not save money by joining an HMO. Medicaid recipients are not as well schooled in institutional confrontations (a prerequisite for demanding care) as are more affluent middle class consumers, and are not in the same bargaining position as employee groups to monitor HMO performance. Further, the role of the State as the negotiator and monitor of the HMO means that the HMO must please state bureaucrats, not necessarily the clients. The needs of both groups do not always coincide. Moreover, the health maintenance and preventive health incentives may not be as applicable to Medicaid HMOs because a patient may no longer be eligible by the time expensive medical treatment is necessary. Rapid Medicaid enrollee turnover—particularly involuntary turn-

over brought about by welfare client ineligibility—can do more than eliminate incentives for preventive care. It can also increase the HMO's marketing and administrative costs, create budgetary uncertainty within the HMO and encourage other methods for containing Medicaid costs, namely, minimizing the provision of primary and acute care.

These are not insurmountable problems. As discussed below, there are ways of addressing these issues. Given the cost of effectively monitoring fee-for-service providers, the perverse incentives in the fee-for-service system, and the benefits and cost savings that could accrue under properly managed HMO arrangements, States should still wholeheartedly endorse this alternative organizational arrangement. The States, however, have not expanded the use of HMOs. In 1978, 16 States had 53 Medicaid HMO contracts with 315,000 Medicaid enrollees. Two years later, 17 States had the same number of contracts but enrollment had fallen to 269,000 (less than 2 percent of the total Medicaid population). Significantly, four States (California, Maryland, Michigan and New York) account for more than half of the contracts and 230,000 enrollees, or 86 percent of the national Medicaid enrollment.[38]

The relatively low level of involvement is the result of a number of factors. States interested in expanding Medicaid participation in HMOs and other alternative financing arrangements have often been frustrated because HMOs do not exist in some areas with large Medicaid populations; existing HMOs are sometimes very reluctant to participate in Medicaid programs; and Medicaid clients have few incentives to enroll in HMOs in those States that provide comprehensive Medicaid benefits.

States, however, need not wait for federal action to dissolve these barriers. These problems, as the previous difficulties with HMOs, can and have been rectified. If carefully designed programs are implemented, the HMO potential can be realized. Medicaid recipients can have ready access to quality care at 10 to 40 percent less than it would have cost in the fee-for-service sector.[39] In considering such an approach states can establish HMO or quasi-HMO relationships with a broad array of organizations. According to federal regulations a State may contract with:

- health care projects grant centers—organizations receiving federal grant funding and providing care to patients;
- health insuring organizations—firms that receive a capitation fee, pay for medical services and assume a financial risk;
- HMOs—organizations federally certified as HMOs under the Public Health Service Act. This is the only type of organization that a State can contract with on an "at risk" basis. All others must be on a cost basis; and
- prepaid health plans—organizations which, according to federal regulations, are "...not an HMO, and that provide medical services under contract with the Medicaid agency to enrolled recipients on a prepaid basis;" i.e., HMOs which do not qualify as federally certified.*[40]

Medicaid's selection of an HMO or type of HMO should be guided by several factors including: 1) the nature of the client population to be enrolled (urban or rural, AFDC or SSI, categorically needy or medically needy, current utilization patterns, etc.); 2) the provider market (i.e., whether HMOs currently exist and, if they do, how they are organized, the willingness of fee-for-services providers to participate or resist the development of HMOs); 3)the capacity of the state Medicaid agency to monitor HMOs; and 4) the role Medicaid contracts might play in developing state policy and addressing specific state problems. One other factor which affects the entire HMO selection process is the federal restriction limiting "at risk" contracts to federally qualified HMOs. If a State is required

*The statutory authority governing the relationship between state Medicaid programs and HMOs and other risk-sharing arrangements has been modified by the Omnibus Reconciliation Act of 1981. For a detailed account of the change, see Appendix A.

to pay all other HMOs on a cost basis, then many of the major advantages and incentives for an HMO would be lost. If a nonfederally qualified HMO is selected, the State should apply for a federal waiver which would permit the State to employ an at-risk capitation rate.

If the necessary federal waivers are granted, States could also choose to purchase care from, and pursue the development of, primary care physician networks similar to the arrangements employed by Safeco on the West Coast and Group Health Plan of Northeast Ohio. With Safeco, a very small number of primary care physicians with 200 or more Safeco employees receive a capitation fee for providing primary care to an individual client and managing the client's health care. The capitation rate covers office visits and outpatient hospital visits, and lab and X-ray services in the physician's office. The physician must operate within the budgetary limits of this rate. If he exceeds it, he assumes the full loss. If his costs are less than the rate, he keeps the difference. A second account is set up to meet the costs for inpatient hospitalization, specialists, outside lab and X-rays and prescriptions. The primary care physician must authorize all specialty referrals, hospital admissions, diagnostic tests and prescriptions. If a service is not authorized, it is not reimbursed. Finally, with the exception of catastrophic costs, the physician assumes some risk for expenditures for specialty referrals and hospitalization. If he exceeds the projected utilization and expenditures, the physician is required to pay the plan up to 5 percent of his capitation rates. Any savings the physician realizes, he shares with the plan.[41] Safeco has recently encountered a number of problems partly due to the fact that most of the physicians were reimbursed on a fee-for-service basis, control over referrals was weak and internal management difficulties were unresolved.

Group Health Plan (GHP) places even greater responsibility and risk on the primary care physician. Again, the primary care physician acts as the entry point for the client's health care and as the manager for that care. GHP's primary care capitation rate, however, includes all physician visits in the office or in the hospital, all surgical operations and procedures, outpatient lab and X-ray, drugs administered in the physician's office, all specialists' care, home care, mental health visits, and speech and physical therapy. The broader inclusion of services for which the primary care physician is responsible makes him more liable for excessive use than under the Safeco plan. Like Safeco, GHP places the primary care physician at risk for inpatient hospitalization up to 5 percent of his capitation rate.[42] The GHP physician, however, will share with the plan any savings from projected hospital expenditures.[43]

State officials can work with major employers to establish new HMOs and other alternative financing mechanisms to serve Medicaid clients. For example, Kansas, under the leadership of Governor John Carlin, and other major Topeka-area employers are jointly developing an HMO.[44] Florida has worked with Palm Beach County officials to develop county run and state/county financed prepaid health plans to serve Medicaid clients.[45] States can enhance their ability to develop and purchase care from more cost-effective delivery structures by designing state employee health insurance program strategies that complement Medicaid program efforts. For example, Contra Costa County, California, has developed a county-run HMO that enrolls principally Medi-Cal recipients and county employees, although enrollment will be open to the general public.[46] In areas with a high concentration of state employees, States may be able to initiate similar alternative delivery structures. Such strategies may be more successful than Medicaid initiatives alone and should reduce the problems that have been experienced with Medicaid-only prepaid health plans.

The State can also use Medicaid funding mechanisms to help save needed institutions that are experiencing severe fiscal problems and, at the same time, develop HMO-like financing structures. California, for example, has considered developing HMOs around county hospitals, which have been financially squeezed by Proposition 13 reductions in

revenues.[47] The rationale for such support is that county hospitals are institutions which not only guarantee access to the poor, but are also major providers of care to the poor. Losing these institutions, therefore, might mean a loss of hospital care for Medicaid clients and other indigent citizens. Similarly, New York State officials are working with New York City Health and Hospital officials to establish prepaid plans for medically indigent and Medicaid recipients served by Metropolitan Hospital in New York City.[48]

Once an HMO has been certified, the State should take precautions to ensure that HMO services are accurately and fairly marketed to clients. To avoid unethical marketing practices and selective recruitment of healthy Medicaid recipients, the State itself could market the HMO through its social workers and monthly check mailings. Recipients willing to join an HMO would be assigned to one near their homes. California has shown that about 17 percent of clients will select HMOs if they are informed of the choice and given the option at the time of their eligibility determination. It is also less costly for the state to market the HMO. Again, in California the State could enroll a recipient into an HMO through the welfare offices at one third the cost incurred when an HMO marketed its services to the clients directly.[49]

States have at least three methods for encouraging HMO selection by clients. They can offer recipients a cash benefit for enrolling (as is now being done in Massachusetts); guarantee HMO eligibility regardless of their welfare status (as will be done in California); or, offer clients a richer benefits package than is available in the fee-for-service sector.[50] Federal regulations exempt services offered by comprehensive health service organizations and rural health clinics from statewide uniformity requirements. Indeed, one way to encourage large scale enrollment would be to widen the gap between the benefits and services available with an HMO and fee-for-service delivery systems.

To assure that proper levels of services are being provided, the State must require medical reports on individuals receiving care. One of the disadvantages of capitation arrangements is that they do away with the fee-for-service invoice. The State must impose reporting requirements on the HMO and require a minimum level of completeness and accuracy in those reports. This could be tested by comparing a sample of HMO reports to the corresponding HMO medical records. Graduated penalties for different error levels between the HMO's reports and the HMO's medical records should be developed. The State should also consider paying for the development of the HMO reporting system and a major portion of its operation, the same way the federal government has funded the development and operation of States' Medicaid Management Information Systems.

The California Department of Health Services has also developed two additional techniques for monitoring the quality of care. The first is a new component of their MMIS system, analogous to the Surveillance and Utilization Reporting System used for fee-for-service, which allows for a more detailed and sophisticated assessment of provider and patient behavior within and among HMOs. The second technique will be used for on-site examinations of an HMO's medical records. It involves a portable minicomputer programmed so that it instructs a nonphysician records analyst to "apply objective criteria statements to the contents of the medical record;" that is, the analyst feeds certain information into the computer regarding the patient's demographic and medical status, and the program responds with a list of specific questions concerning procedures that should have been followed.[51]

A problem with Medicaid is that recipients are involuntarily "disenrolled" when they become ineligible for welfare. This problem has several disturbing implications for HMOs. First, a high turnover rate (and there are some indications that Medicaid recipients turn over, or disenroll, two to seven times as fast as non-Medicaid recipients) disrupts the HMO's ability to budget and plan for the future.[52] Second, combining involuntary disenrollment and disenrollment because of dissatisfaction with an HMO, camouflages the extent of client dissatisfaction with the HMO. Recent changes in

federal law provide States with some leverage to rectify these conditions. In terms of involuntary disenrollment, States are now permitted to establish minimum enrollment periods of up to 6 months for Medicaid clients enrolled in federally qualified HMOs with guaranteed continued federal payments during that period even if Medicaid eligibility is lost.* As a matter of practice, States could also extend HMO coverage for 31 days beyond termination of eligibility due to a failure of the client to show up for face-to-face recertification appointments. In several States with HMO contracts, HMOs have complained that the recertification process disenrolls a client for not keeping an appointment. If the client appears several hours later he may be reinstated, but he is then placed back in the fee-for-service system.

In addition, the State should also negotiate a disenrollment standard with the HMO based on non-Medicaid disenrollment within the HMO or HMOs throughout the area or State. If voluntary Medicaid disenrollments exceed that standard, the HMO would be penalized. If they are less than the standard, the HMO should be rewarded. Note that since involuntary disenrollment will also be included in the non-Medicaid standard (e.g., a family is transferred by a company out of the HMO service area), the standard will be inflated. Finally, the State should keep thorough records on who voluntarily disenrolls and why. The HMO should understand that continued participation in Medicaid requires, in part, that unacceptable patterns do not appear among voluntary disenrollees. The HMO should also be informed that the enrollment guarantee will not apply to individual clients who can show why they must be allowed to seek medical care elsewhere.

The State generally sets capitation rates by making them equal to a percentage of the costs experienced by a comparable population in the fee-for-service sector (e.g., the rate could be 90 percent of what the State would have had to pay if the HMO enrollees had remained in the fee-for-service system). Usually, the comparison is based on a fee-for-service population adjusted for the age, sex, location and program (AFDC or SSI) of the HMO population. This technique carries with it two potentially expensive implications. First, family size can dramatically affect per capita Medicaid costs.[53] If the State does not adjust per capita payments for case/family size, it could set its rates too high. Without knowing the cost relationship between case size and per capita expenses, the HMOs could concentrate on enrolling the larger cases because the enrollment cost per capita decreases as the case size increases. (This assumes that, as in one case, the State informs the HMO who is eligible and how many individuals are in all the cases within the HMO's catchment area.) The second factor relates to the medically indigent population. This group, by definition, has incurred substantial medical expenses. They are unlikely to be enrolled by an HMO and their costs should not be included in the calculation of the fee-for-service costs.

*For a more extensive discussion of this change, see Appendix A.

CHAPTER V

MINIMIZE ELIGIBILITY ERRORS

Reducing eligibility errors is a strategy that enjoys tremendous political and programmatic appeal. It does not affect the state's basic eligibility criteria, restrict benefits or interfere with providers in the delivery of care. However, efforts to purge the system of ineligibles are not without costs. Politically, recipients and welfare rights organizations can argue that certain measures constitute harrassment and denial of basic constitutional rights. Similarly, providers might attempt to block any action that requires their cooperation and attempts to link, for example, their reimbursement to their performance on a specific task (e.g., checking Medicaid card and additional ID). Administratively, the State must assume its proportionate share of the costs of designing the new policy to reduce errors. Specifically, the State must be willing to make the appropriate changes in its computer system; write new regulations; train staff; overcome staff resistance; and assure that the outcome of the new policy is within the predefined realm of acceptability. Finally, if program managers incorporate a politically popular campaign to rid the Medicaid program of "the last welfare cheat," they may forget that the costs of such an endeavor must outweigh the benefits.*

Despite these drawbacks, if the States eliminated eligibility errors and restricted services to only those for whom the program was intended, an estimated $2 billion in State and federal Medicaid expenditures would have been saved in 1978 alone.[1] As States are fully aware, DHHS is under a Congressional mandate to impose sanctions on States whose error rates exceed federal standards. The factors responsible for misspent funds can be grouped into three broad categories: structural errors, administrative errors, and client errors.

Structural Errors

Structural errors in eligibility determination result from poorly conceived, ambiguous, and/or complex federal regulations which States are required to follow and administer. Included among the "unworkable" federal policies identified by the Urban Systems' comprehensive review of Medicaid eligibility were procedures for: determining spend-down cases; establishing the medically needy level; determining eligibility for retroactive coverage; treatment of income and resources; determining residency; and

*As the more blatant ineligible cases are purged from the system, it becomes increasingly difficult and costly to discover and substantiate additional cases of ineligibles. Further, the complexity of the program guarantees that there will be a continued flow of incorrectly processed individuals.

determining eligibility for extended coverage.[2] Eligibility errors that result from a State's failure to abide by these and other federal regulations, which are difficult or impossible to administer without error, must be viewed as inevitable and part of the structure of the program. The States can take few corrective actions because a large portion of the "misspent" funds resulting from such structural problems cannot be recovered without changes in federal policy.

Administrative Errors

Administrative errors are the result of ill-conceived state policy, imprecise and confusing state regulations and forms, inappropriate organization, insufficient and inadequate staff, and a failure to monitor adequately the operation of field staff and central management. The role and position of the eligibility determination worker (EDW) is critical in the process of reducing administrative errors. For example, in 1975 each of Connecticut's EDWs was responsible for approximately $1 million in AFDC and Medicaid payments. Yet the job requirements for an EDW was two years of college or related experience. The entry level salary was $7,509 a year. And supervisors frequently complained that some workers lacked the basic writing and math skills to do their jobs.[3] Connecticut's situation was typical of most States where low paid workers frequently lacking rudimentary skills were given broad discretionary authority, asked to administer an extremely complex program, and made the gatekeepers for millions of state dollars. Policy and procedural changes must continually acknowledge the strengths and limitations of the particular State's EDW workforce. With this in mind, the following actions can be taken:

1) Clarify rules and regulations: Regulatory language should be simple, straightforward, precise and free of jargon. The State should periodically review its regulations by surveying its EDWs for identification of problems and ambiguity in the regulations and procedures. Illinois has developed such a questionnaire for its EDWs and uses it "to decide whether to publish a separate Medicaid manual, change the format of current manuals, establish training programs, or revise current policies."[4] Another useful check is having upper level management read the EDW manuals. If they find the regulations unintelligible, changes are in order.

2) Simplify EDW responsibilities: Frequently the EDW is responsible for many of the state's welfare programs, each of which has its own regulations and procedures. The efficiency of this process would be improved if the States allowed the EDW to specialize in a particular program or a portion of a program for the eligibility determination process. Specialization permits greater understanding of the program at hand while making few demands on the EDW. The EDW can specialize at the level of Medicaid itself rather than all welfare programs or, as is done in Massachusetts, in the specific programs within Medicaid, such as the nursing home program.

3) Improve EDW performance: Given the considerable state resources that an EDW typically manages, the State can reduce the caseload size and improve its performance through such strategies as: increasing EDW requirements for education and experience; providing improved on-the-job training; using error-prone profiling; developing preapplication screening processes; instituting a program for evaluating the EDW's performance; and setting acceptable performance standards.

Caseload reduction responds to a complaint often voiced by EDWs that caseloads are too large to screen eligible applicants effectively. It may require the employment of additional EDWs with an attendant increase in administrative costs. However, this added cost may be small in comparison to the savings resulting from the identification of ineligibles that potentially flow from more EDW time spent per applicant.

Increasing the job requirement for education and experience may also improve EDW work proficiency. In some States such efforts require increased salaries to attract suitable

applicants. However, an intermediate step would be to test each EDW applicant for the writing and math skills necessary to do the job. This assumes that the state or local civil service tests do not adequately screen job applicants.

On-the-job training for EDWs currently ranges from nonexistent or haphazard to extensive. If training is structured and uniformly applied, the State can improve the effectiveness of the EDW and reduce eligibility errors. The San Francisco Department of Social Services has a four-month training program for new EDWs which consists of one month of induction training, followed by three months of field work with a reduced caseload and supervision from experienced staff. The program has contributed to a reduction in the AFDC error rate from 20 percent in 1975 to 3 percent in 1978.[5] Los Angeles County uses a multiple choice and true/false test to assess the EDW's understanding of policies and procedures. Those who do not score 80 percent or higher on the examination are required to receive training.[6]

Error-prone profiling is a procedure based on the fact that the distribution of eligibility errors is not spread evenly across the recipient population. It has been estimated that 15 percent of the recipient cases represent 80 percent or more of total Medicaid eligibility errors.[7] Those cases with a high likelihood of error can be identified through error-prone profiling, a procedure similar to the IRS audit determination. This is a statistical approach which estimates the probability that a given caseload characteristic (e.g., earned income, length of time on the rolls, the size of the case, etc.) will be associated with an error. Once this system is in place, a State can focus its EDW efforts much more effectively and lucratively. States utilizing profiling methods, however, should evaluate the characteristics of the error-prone group before targeting remedial programs. In some cases, the assumption that more EDWs or other resources will reduce errors among prone groups is not valid. If, for example, eligibility standards or the determination process are awkward and simply do not work well with a particular group (e.g., nursing home recipients), spending additional resources may be fruitless. Error-prone profiling requires a client information system, a statistical package which profiles clients and identifies groups with the highest likelihood of errors, and an assessment component which can evaluate the effect of error-prone profiling.[8] Several methodologies are available, some of which profile according to the type of error, while others focus on the overall probability of error. To date, the results of profiling efforts have been positive. In New Hampshire, for example, profiling produced a 7:1 benefit-to-cost ratio in several of the local offices participating in the experiment.[9] Profiling is potentially a highly effective management device which every State should consider.

Preapplication screening is the first part of a two-stage eligibility determination process which can improve EDW performance. The screening process consists of administering a simplified application which identifies those factors which most frequently disqualify an applicant. If the applicant meets the requirements for eligibility in the first stage, he is scheduled for a formal intake interview and given a list of the necessary documents he must produce. This approach has been successfully tested in San Diego County.[10]

To maximize the efficiency and effectiveness of EDWs, the State should develop programs or standards which can enhance worker and/or office performance. Front-end controls, such as qualifications, training, etc., are methods to achieve improvement. In addition, the State may establish minimum acceptable standards of productivity. For example, the State may adopt as tolerance levels for welfare office errors the federal, state or regional average rates. For administrative units or offices, such a practice requires local jurisdictions or counties to bear a percentage of the administrative costs due to excessive errors. Similarly, bonuses can be given to those administrative units whose error rates are below the standard.

4) Improve the Flow of Information: Even if one assumes that all clients are eager and

willing to report personal changes affecting their eligibility status, and if the district offices are willing to notify the central office quickly of any changes in eligibility, these conditions are still insufficient. Channels for this information exchange must exist for appropriate actions to be taken. The State, therefore, must assure that any client wishing to report a change in his status can do so easily. In Connecticut, for example, a special legislative committee recommended that a telephone service be made available to clients for the sole purpose of reporting eligibility changes, that the service be well staffed, in operation longer than the standard daily 9 a.m. to 5 p.m. period, and highly publicized.[11]

The second part of the information chain requires an accurate and rapid flow of information between the district offices and the central office. Virginia, for example, permits EDWs to phone in eligibility data to a central terminal, and in large metropolitan areas, terminals are physically located in district offices. The direct tie-ins are more efficient and faster than the mail or the use of paper transmittals in maintaining current files.[12]

5) Use of Medicaid ID Cards: Some form of Medicaid identification is currently in use in most, if not all, state programs. Misuse of these cards by formerly eligible applicants deemed ineligible, or by individuals who illegally "borrow" an eligible recipient's card, are significant problems in many States. Several proposals have been offered as solutions to these problems. These include reissuing cards regularly, noting the expiration date on the card, requiring additional identification, retrieving the card when a Medicaid recipient becomes ineligible, and using photo ID cards. All of these options should be considered. The most controversial—the photo ID—is currently being used in 10 States.[13] While the photo ID may give rise to claims of civil rights violations because of sex or race discrimination, this can be overcome if the State carefully adheres to the appropriate legal requirements. Further, it may be advantageous not to have a uniform ID card policy for all clients. Georgia, for example, issues a color photo ID for all clients except nursing home patients.[14] In a similar vein, cards could be reissued monthly for some categories of clients, and on a six-month basis for others, depending on the rate of client turnover, the institutional status of the clients, and historic patterns of abuse within a client category.

If the States can successfully control their error rates, there are other actions that may be taken to control administrative costs. For example, in 1976 California implemented a mechanism to reimburse county welfare departments for administrative costs which resulted in significant savings. In essence, this program limits local administrative costs by imposing and enforcing acceptable standards. Previously, the counties had billed, and been reimbursed by, the State for all administrative expenses. With the new program, local units are reimbursed for administrative costs that do not exceed the average for counties of equal size and caseload. As a consequence, the rate of increase in administrative costs dropped from 30 percent in FY 1976 to 9.9 percent in FY 1978 and 1.1 percent in FY 1979.[15] If a State imposes similar restrictions on its administrative agencies, it should also monitor error rates, since savings that result in a higher error rate are, of course, no savings at all.

Client Errors

Client errors consist of false, incomplete or untimely reports by clients which affect their eligibility. States can adopt several strategies to limit such errors. First, as a condition of eligibility, the State can require that clients submit monthly or quarterly reports. These reports increase the ease with which a client can report changes and also act as a mild deterrent to fraud, since recipients whose situations have improved would be obligated legally to document that change or be subject to legal sanctions. Careful attention must be given to problems such as client illiteracy or, as in the case of nursing home clients, those situations where clients can rarely provide eligibility information about themselves.

Second, fraud can be deterred by requiring yearly face-to-face certification of clients by EDWs. This has proven very effective in some States. Allowances must be made for clients to reschedule certification dates if the weather is inclement. This policy may also increase administrative costs if additional personnel are needed to process client reports and conduct interviews, or if the State must provide client transportation.

Third, States should closely monitor client reports. The most efficient mechanism for monitoring is a computer match between the Medicaid client information system and other data systems that contain relevant client information. Among the most prominent data systems available are:

- State Data Exchange (SDX), a federal data system for Medicaid, Retirement, Survivors and Disability Income Insurance, Railroad Retirement Program, and Black Lung Benefits;
- State income tax files;
- State motor vehicle files;
- Circuit court registers; and
- School districts.[16]

Fourth, providers can be required to verify client ID by checking specific identification with the department if there are any questions. The State should develop and/or maintain an automated on-line eligibility file with telephone access available to all providers. This action, however, may increase provider administrative costs and may result in a reduction of provider participation in Medicaid. Nonetheless, 39 States are currently responding to provider inquiries concerning client eligibility.[17]

Finally, the state fraud unit should be highly publicized. If clients and providers know that the State has an active fraud unit, with the strong backing of the governor and other prominent state officials, potential abuse may be greatly curtailed.

CHAPTER VI

MINIMIZE MEDICAID'S SUBSIDY OF OTHER PAYORS

The Medicaid program was meant to serve as the payor of last resort for those who had exhausted all other resources; however, this purpose is often frustrated by a number of factors. Frequently, States fail to: uncover private health insurance that a recipient might have; pursue liability and workmen's compensation cases; require clients with other government coverage (VA, CHAMPUS, Black Lung, etc.) to exhaust those benefits before coming to Medicaid; act on behalf of Medicaid assault victims where the courts have required that the assailant make restitution for medical expenses; find absent parents who can and should provide medical coverage; actively file claims in probate court. The result has been the loss of millions of Medicaid dollars. Indeed, one estimate places this loss of unclaimed benefits, referred to as third-party liabilities (TPLs), at 4 percent of total Medicaid vendor payments, or about $786.5 million in FY 1979.[1] If anything, this underestimates Medicaid's subsidies of other parties, given that States may fail to thoroughly audit their own Medicaid fiscal agent as well as Medicaid providers. Moreover, this estimate does not include the overpayments made to providers that serve as interest-free loans or the State's failure to squeeze all of the federal dollars out of its Medicaid program. (Those untapped dollars are not claimed and, therefore, do not show up on the federal Medicaid ledger.) These are substantial resources that are insufficiently tapped and relatively easy to acquire. Nonetheless, TPL alone is a very attractive financial exercise. For example, Minnesota invested $263,000 in TPL administrative costs in 1979 and recovered $9 million.[2] North Carolina's TPL program recovered $6 million in 1979 on administrative costs of $120,000.[3]

The federal requirements on third party liability are clear. Specifically, the States are required to:

- ascertain the legal liability of third parties;
- treat known legal liabilities as a current resource;
- pay the provider when and if the legal liability of a third party is in doubt, or when payment will not be reasonably prompt; and
- seek reimbursement from legally liable third parties.[4]

While federal regulations are unambiguous, they lack the specific legal authority to permit States to implement a TPL program aggressively. Minnesota solved this problem by passing legislation which: 1) gave the Department of Public Welfare the rights of assignment and subrogation for each client; 2) prevented private insurance carriers from

writing contracts which terminated or restricted coverage if an individual was found eligible for Medicaid; and 3) allowed the State to file a lien for a year after its last medical payments for a client "against any and all causes of actions."[5]

Client probate is another area where States may need additional authorizing legislation, even though federal probate regulations enable recovery from estates of individuals over 65 who are not survived by a spouse or child under 21. In Maryland, for example, special state legislation authorizes estate recovery, but requires consideration of hardship cases. Maryland's probate recoveries alone totalled $3 million in 1979 while administrative costs were about $150,000.[6]

Carrier Subsidies

Medicaid not only tends to subsidize its clients' private insurers and other responsible public programs, but there is a likelihood that when the State contracts the auditing of providers and processing of bills to an independent agent, it also subsidizes that agent. For example, if the agent reimburses hospitals on the basis of costs, it has a very strong incentive to shift as much of its own share of hospital costs onto Medicaid as possible, thereby lowering its commercial premiums and becoming more competitive. The argument is not that fiscal agents will do this; only that there is a strong incentive in that direction. States should perform periodic, thorough audits of their agents. Penalty clauses should be written into contracts if incorrect Medicaid charges exceed a given dollar amount and/or percentage of total Medicaid expenditures.

The alternative to contracting the fiscal agent function to a private firm is for the State to administer this portion of the program itself. Half of the States have, in fact, done this and have established respectable records as fiscal agents. Once a State has demonstrated its ability to administer, manage and control its Medicaid program, it should seek to expand and act as the third party for Medicare. Control over both Medicaid and Medicare would carry enormous implied power which would permit the State to bargain more effectively with its major providers and might deter provider manipulation of Medicare accounts. Currently, only Oklahoma acts as a Medicare carrier and only for Part B (physician) benefits. Michigan, however, has applied to DHHS to act as the carrier for Medicare. This is a promising area of expansion with important cost-containment implications.

Employer Subsidies

Medicaid acts as a health benefit for (and therefore subsidizes) small employers who do not provide health insurance for their employees. The State could alter this situation by mandating minimum coverage responsibility by employers. The State itself could set up an insurance pool for these employees, thereby acting as the agent for small employers.[7] The State also could mandate that all private insurance remain in effect from 45 to 60 days[8] following termination of employment. In addition, the State could subsidize health insurance premiums for the working poor.

Colorado is considering legislation which would finance the purchase of subsidized health insurance for poor people not eligible for Medicaid. State officials considered and rejected expanding the Colorado Medicaid program to include a "Medically Needy" program. The Colorado Health Care Cost Protection Act would subsidize insurance for those too poor to buy it and extend catastrophic insurance to all Colorado citizens.[9]

Hawaii requires, while Rhode Island provides incentives for, private sector health plans to provide a specified minimum coverage of services. These programs protect state residents from impoverishment resulting from medical expenses and reduce the potential number of individuals who have incurred out-of-pocket health care expenses large enough to become eligible for Medicaid Medically Needy programs. Such programs thereby help reduce state expenditures.[10]

Family Subsidies

Families capable of contributing to the care of a family member have also been freed of that obligation and subsidized by Medicaid. The State should explore the possibility of making parents responsible for all children under 21 and all college students. One reason for doing this would be consistency in standards for eligibility. Thus, if state Medicaid coverage is extended to children in eligible families up to age 21, when those families are able they should assume responsibility for their children. This expansion of parental responsibility might also include holding stepparents responsible for their stepchildren's health care needs as well as requiring working husbands with private insurance to continue coverage of their family even after a divorce is final. This latter action was under consideration by the Oregon Legislature during its 1981 session.[11]

In terms of encouraging filial contributions, the State could design a permissive relative-responsibility requirement for adult children and relatives (other than spouses) of elderly patients in nursing homes. This would encourage, but not require, contributions by relatives. It would, therefore, circumvent the need to impose a means test on children to determine the amount they would be required to pay, or deal with such thorny issues as the collection of the children's obligation when they live out of state or refuse to contribute. The extension of parental and filial responsibility would require a waiver from DHHS although it is not clear whether DHHS would have authority to grant such a waiver.

During 1981 two States devoted considerable attention to promoting filial responsibility. Idaho enacted a law creating an account for relatives of Medicaid recipients in nursing homes to contribute to voluntarily. The account is to be used to offset the cost of nursing home care. Individuals who make a contribution to the account can claim it as a donation on their state income tax returns.[12]

Wisconsin, on the other hand, considered legislation which would require the State's Department of Health and Social Services to seek a federal waiver in order to require individuals (children 18 or older) with a parent in a nursing home, foster home or community-based residential facility, to contribute to the cost of care of the parent. An individual's liability would be based on his gross income—those with a minimum of $30,000 annually would be liable for $3.25 per day, while individuals earning over $115,000 would be liable for the entire cost of care.[13]

One eligibility change that would not require a waiver and which could be adopted immediately by States is the limitation on transfer of assets for the purpose of obtaining eligibility for Medicaid under the Omnibus Reconciliation Act of 1980. States are now permitted to consider any uncompensated transfer of assets which may have taken place up to two years prior to an individual's application for Medicaid coverage. If the value of disposed assets was greater than $12,000, the State may refuse an individual Medicaid status.[14]

Medicare Subsidies

The Medicare program is a potential financial resource which many States do not fully take advantage of. Failure of Medicaid to fully tap Medicare, in essence, provides a subsidy from the State to the federal government. States, for example, are not required to pay the hospital coinsurance or deductibles for their Medicare buy-in clients (typically, these are elderly Medicaid clients who are eligible for Medicare and whose Medicare premium is paid by the state Medicaid program). Hospitals, however, could treat the unpaid coinsurance and deductibles as Medicare bad debts and would receive reimbursement for these costs from Medicare.

States can also require that all skilled nursing facilities which participate in Medicaid also participate in Medicare. Given that the certification requirements for SNFs are iden-

tical in both programs, it could be expected that the mandatory participation requirement would only be beneficial to the State. Medicare, after all, covers 100 percent of the cost of the first 20 days in a nursing home and 78.5 percent of the following 100 days. As David Smith has observed, however, States must carefully assess the number of potential Medicare days "lost" because some homes refuse to participate in the Medicare program.[15] Because the administrative costs incurred by the State and the homes in the adoption and maintenance of Medicare cost reports is significant and because 21.5 percent coinsurance which the State would pay on 100 days of care would be based on Medicare's higher per diem, the net savings to the State may not be as great as expected.

Maximize the Purchasing Power of the State

The State should attempt to squeeze every advantage and dollar it can out of its enormous purchasing power. Two ways that States can do this are through bulk purchase agreements and by acting as a supplier for major providers.

Bulk purchase agreements should be considered for any class of medical goods—from pharmaceuticals to eyeglasses—which are used above some threshold volume and/or cost level. For example, the State could consider only goods which are consumed by 5 percent or more of the recipient population and represent 2 percent or more of total Medicaid expenditures. (Smaller States might consider an absolute minimum dollar amount, such as $2 million in expenditures, as a more appropriate standard.) In general, the State has three basic options on bulk care. The State can: 1) contract with a manufacturer and have all Medicaid retailers deal only with that manufacturer or accept the manufacturer's price; 2) contract with a manufacturer and act as the wholesale distributer; and 3) not only negotiate with a manufacturer and act as the wholesale distributor but also act as the sole or major retailer (that is, the State would provide the good or service directly to the client). The latter two options are administratively complex and may involve some costs. Moreover, acting as the sole retailer could potentially be in violation of the freedom of choice provision. Finally, there may be both strong State political and legal restrictions which prohibit the State from directly competing with the private sector.

In terms of bulk purchase, the model that States have most frequently adopted has been to request bids from manufacturers for the production and supply of a given good, award the contract, and then have retailers deal with the manufacturer. Washington State has been an innovator in this area, and its bulk purchase of optical lenses has served as a model for other States. Washington's current contract with Western Optical specifies delivery time, quality standards as stipulated by American National Standards, and a 90-day guarantee.[14] The professionals who write the prescriptions and dispense the glasses receive a dispensing fee. (The providers are not bound to purchase the lenses from Western Optical. The State, however, will not pay the providers in excess of the price set by Western Optical.)

Michigan used the Washington model when it contracted with a lens producer. First, the State set up a task force of optometrists, opticians and ophthalmologists to set the specifications for the program and design the request for a proposal. This ensured cooperation from professionals and produced a workable program for both providers and the State. The discussion of reimbursement was put off until the last meeting of the task force, and the State gave the doctors their implicit dispensing fee for bi- and trifocals. However, by eliminating profit on the product (and anecdotal information suggested that optometrists had been able to buy lenses for $2 and charge the State $10), the State expects to save $500,000 this year.

California is considering an interesting variation on this theme: it would request bids for all generic drugs reimbursed by Medicaid. The company winning a particular bid would establish the price for that generic drug. Any participating pharmacy could purchase the drug from that company. In any event, the pharmacy would not be reimbursed

above the rate set by the company with the bulk volume contract.

The State could also explore the possibility of supplying nursing homes with a medical director and/or making dental care arrangements for the home's patients. The direct state provision of professional services which nursing homes often find difficult to provide would assure that the services were delivered and probably at a cost well below that which the home might charge. The State could also allow the nursing homes to avail themselves to state contracts for bulk purchases of pharmaceuticals and supplies. These options would require careful study and probably a federal waiver.

CHAPTER VII

RELATIONSHIP WITH LOCALITIES

The important role that localities play within a State's health delivery system should be recognized. The State should not adopt a cost containment policy which may lead to a shift of the financial burden onto counties and cities. Localities are, after all, creatures of the State; their citizens are also state citizens. A shell game which shuffles additional medical costs onto local budgets may prevent localities from fulfilling their traditional local functions. Currently public facilities, particularly public hospitals, act to:

- extend services to all those without any public or private health insurance coverage;
- guarantee access to Medicaid clients regardless of changes in state policy; and
- provide services that private institutions frequently do not offer (treatment for acute mental illness, alcoholism or drug dependency, extensive outpatient and emergency care for individuals without a primary care physician, poison centers, burn units, etc.).[1]

If these functions are weakened, many individuals will be left without any source of medical attention. In addition, the public sector's ability to negotiate with the private sector is compromised and its ability to judge the reasonableness of the private sector's performance is reduced. It should be stressed, however, that the State's goal should be the preservation of these functions, not necessarily local institutions. California and New York are attempting to save local hospitals with the Medicaid program and state assistance. Another approach could be a joint state-local venture to save the functions. This has, in the past, taken place with Project Health in Multnomah County, Oregon.[2]

Project Health was developed in 1973 by the county after the state legislature transferred control of the county hospital to the University of Oregon. This freed up $4.2 million which the county could use to provide care to the medically needy. The means for accomplishing this, however, are slightly unorthodox. First, the county pools its health financial resources from all available sources (county funds, public health service (330) grants, Medicaid, client payments and provider refunds). Second, the county acts as a broker for its clients by negotiating prepayment contracts with five prepaid health plans and also by offering an episodic care plan which pays for office visits to individual physicians and has limited hospital coverage. All prepaid plans have a minimum benefit package which they must offer. The plans, however, differ slightly with respect to the extent of coverage, whether or not copayments are charged for specific services, and the dollar amount, depending on family income and size, clients must contribute to their capitation rate. Project Health provides services to the 12.5 percent of county residents considered

medically indigent. During 1979, 4,670 individuals were enrolled in one of the prepaid plans and 642 chose the episodic care plan. The total cost in 1979 was $8,130,000.[3] Proponents of Project Health argue that it offers the best mix of policy goals available. Specifically, the claims are that Project Health allows the consumer freedom to choose among participating providers; makes consumers more involved and sensitive to costs by requiring copayments and premiums; and stimulates competition among health care providers.

Project Health also ostensibly encourages cost containment through prepayment; integrates fragmented public programs by pooling resources and centralizing the source of program benefits; and leans in the direction of a voucher system, i.e., it offers financial assistance to eligible individuals and assists them in making intelligent choices, rather than acting merely as a financial conduit for providers.[4] A number of studies have examined Project Health and more are underway.[5] Project Health's approach to health care undoubtedly will receive increased attention under the Reagan administration and should be considered by other States and localities.

In the short term, the major problems facing localities is that when Medicaid becomes more restrictive and less lucrative, private institutions and providers turn Medicaid patients away, which often means that they send them to public facilities. As a result, the localities not only have to care for more Medicaid patients but they receive less for each patient served. The issue, then, is how can the State minimize the likelihood that clients will be "dumped" onto public facilities. The following policies are intended only as examples and are not meant to be an exhaustive list of alternatives:

- Adopt a policy that the dumping of patients onto public facilities is a violation of state licensure.[6]
- Regulate Medicaid and private rates.
- Prohibit nursing homes from charging private patients more than their Medicaid patients. Thus, if a home remains in the program (and it is unlikely that more than a few can drop out), there is no financial incentive to admit a private patient rather than a Medicaid patient and no justification to push a private patient out of a home because he becomes a Medicaid client. (Minnesota has adopted this policy for its nursing homes.[7]);
- Require all payors to recognize their fair share of the costs of providing hospital care to the truly indigent — those impoverished but ineligible for public programs. This requirement is incorporated in the rate setting methodology developed in New Jersey and Maryland.
- Require nursing homes that participate in Medicaid to accept Medicaid patients up to a reasonable limit. (Seven States currently have such a mandate.[8]) In Ohio, for example, a home must accept a Medicaid patient if less than 55 percent of that home's patients are in the Medicaid program. Under no condition, however, is a home allowed to force a former private patient to leave because he had exhausted his resources and became a Medicaid client.[9]
- Require hospitals to accept Medicaid patients. Legal advocates for the poor in Tennessee have developed a strategy to require all voluntary nonprofit hospitals which have received Hill Burton funds to accept any Medicaid patient seeking care as long as the patient has some hospital coverage. The rationale for this requirement is based on the Community Service Regulation of the Hill Burton Act — a regulation which is indefinite in that the hospital is obligated to abide by it for the life of the institution — and certain aspects of the IRS regulations governing nonprofit hospitals.[10] The Tennessee approach has not yet been tested in the courts.
- Mandate insurance companies or HMOs doing business in the State to accept some responsibility for health care of the indigent. "This could be done either through a

requirement that the health care service plans hold open a certain number of enrollment slots for indigents or, alternatively, by establishing a new public entity that would administer an explicit risk-pooling program."[11]

Most of these options impose what Richard Posner[12] has termed "taxation through regulation." For example, if the Medicaid rates are insufficient for providers to cover their costs, providers normally can respond by either becoming more efficient, lowering the quality of care, requiring non-Medicaid patients to subsidize Medicaid patients, exhausting their endowments and reserves, and/or turning Medicaid patients away. These options, on the other hand, generally do not permit providers to turn patients away. Thus, providers are forced to alter their internal behavior or subsidize the Medicaid patient.

CONCLUSION

This paper has presented a number of strategies that States can draw upon in order to contain Medicaid costs. States can and have obtained significant savings by improving and tightening Medicaid program policies and administration in the ways discussed here.

Title XIX of the Social Security Act was designed to "buy into" the existing private health delivery system. The law provided clients free choice and obligated States to reimburse any qualified provider who rendered a covered service. There was a strong institutional bias both in the placement of recipients and the generosity of payment. Alternatives to the fee-for-service system have not been actively pursued by the States, in part because they were effectively discouraged by federal requirements. The 1981 Omnibus Reconciliation Act will serve to change this regulatory environment.* States will have wide latitude to develop alternative financing structures and more leverage to negotiate with providers. Eventually, Medicaid costs will reflect cost increases in the health care system at large. Those increases are projected to exceed the rate of increase in state revenues. State Medicaid program refinements can compensate for this reality to a degree, but not completely or indefinitely. Indeed, some States had virtually exhausted Medicaid cost containment options available under the law, reaching a point where it was extraordinarily difficult to realize further savings other than through reducing service coverage and restricting eligibility. Fortunately, a significantly expanded range of options is now available to these States.

Ultimately, if States are to continue to provide the current level of medical services to the poor, total health care cost escalation will have to be substantially reduced or Medicaid programs will have to be restructured. There are a variety of strategies that States can pursue—all of them radical departures from the current Medicaid program. Massachusetts' proposed restructuring of its program around private intermediaries,[1] California's proposed organized health system[2] and Oregon's proposed voucher approach[3] vary substantially from traditional structures, and require waivers from many Medicaid requirements. A more global attempt to restructure a State's entire health care system is being contemplated in Kentucky.[4] We may well have reached the point where marginal modifications and tinkering are insufficient. Radical departures become more acceptable when traditional approaches lead to constant and seemingly unresolvable crises. We may be entering a period which will be receptive to just such departures. The recently enacted changes in Title XIX of the Social Security Act would strongly suggest that this is in fact the case.

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*See Appendix A

FOOTNOTES

Chapter I

[1] Donald N. Muse, National Annual Medicaid Statistics: Trends in Medicaid Data: FY 1973 to FY 1979 and Detailed State Tables for Fiscal Years 1977, 1978 and 1979 (Internal Working Paper), Office of Research, Demonstrations and Statistics, Health Care Financing Administration, Department of Health and Human Services (August 1981), p. 8.

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[3] Interview with Vern Smith, Director of Program Policy, Medical Services Administration, Michigan Department of Social Services.

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[5] I. Burney, G. Shriver, M. Blaxall, J. Gable, "Geographic Variations in Physician Fees: Paying the Physician Under Medicare and Medicaid," Journal of the American Medical Association, Vol. 240, No. 13, September 22, 1978.

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Chapter II

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[5] Muse, pp. 23-24.

[6] Omnibus Reconciliation Act of 1980 (PL 96-499), 96th Congress, 2nd Session, Section 962.

[7] For example, see 8-volume report on Medicaid nursing home reimbursement in California, Colorado, Connecticut, Illinois, Louisiana, Minnesota and New York by Bruce Spitz and Jane Weeks, Medicaid Nursing Home Reimbursement, Health Care Financing Grants and Contracts Report, forthcoming.

[8] Omnibus Reconciliation Act of 1980, Section 962.

[9] Omnibus Reconciliation Act of 1980, Conference Report No. 96-1479 to Accompany HR 7765, p. 154.

[10] *Ibid.*

[11] Bruce Spitz, Medicaid Nursing Home Reimbursement in New York, Washington, D.C., The Urban Institute Press, 1980, p. 59.

[12] For an excellent discussion of the implications of reimbursing on a facility-specific basis versus industry performance, see William Pollak, "Long-Term Care Facility Reimbursement," in John Holahan, et al., Altering Medicaid Provider Reimbursement Methods, pp. 103-142.

[13] This policy could be successfully challenged by the nursing homes. See, for example, *Long Island College* vs. *Whalen,* New York Supreme Court, Appellate Division, Third No. 34661, May 24, 1979.

[14] Correspondence from Paul Allen, Director, Medical Services Administration, Michigan Department of Social Services, to Dick Merritt, Director, Intergovernmental Health Policy Project, June 15, 1981.

[15] West Virginia Department of Welfare, "Medicaid Long-Term Care Systems," unpublished, undated; Thomas Walsh and Mike Koetting, "Patient-Related Reimbursement for Long-Term Care," unpublished, undated; "Field Test Point Count Guidelines: March 1980," Illinois Department of Public Welfare; Peter Shaughnessy and Bettina Kurowski, "Quality Assurance Through Reimbursement?" Center for Health Services Research, University of Colorado Health Sciences Center, December 1980; Bruce Spitz, "The Missing Link: Quality of Care and Reimbursement," unpublished.

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home reimbursement system is excerpted from Bruce Spitz', "The Missing Link: Quality of Care and Reimbursement."

[17] The 14 categories of service are: 1) Behavioral/Mental; 2) Personal Hygiene; 3) Eating; 4) Mobility; 5) Appliances; 6) Oral Medications; 7) Injections; 8) Dressings; 9) Incontinence/Catheter; 10) Enema; 11) Suctioning/Tracheotomy; 12) Oxygen/Aerosol Therapy; 13) Colostomy/Ileostomy/Ureterostomy; and 14) Intravenous/Subcutaneous Fluid.

[18] The six categories are: 1)general habilitation; 2) special services; 3) physical therapy; 4) occupational therapy; 5) speech and audiology; and 6) psycho-social service.

[19] Ohio Department of Public Welfare, Patient Assessment System Linking Medicaid Payments.

[20] For example, see: Bruce Spitz and Jane Weeks, Medicaid Nursing Home Reimbursement in Illinois, Washington, D.C., The Urban Institute Press, 1980, and Bruce Spitz, Medicaid Nursing Home Reimbusement in New York.

[21] Bruce Spitz and Jane Weeks, Medicaid Nursing Home Reimbursement in Minnesota, The Urban Institute Press, 1980.

[22] Reimbursement Alternatives for Long-Term Care, Jefferson City, Missouri, Missouri Office of Administration, Division of Budget and Planning, 1979.

[23] David Wyant, presentation at the Medicaid Cost Containment Conference, National Conference of State Legislatures/Intergovernmental Health Policy Project, Boulder, Colorado, March 1981; Comptroller General, State Audits to Identify Medicaid Overpayments to Nursing Homes, HRD-77-297, GAO, January 1977.

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[26] Russ Hereford, "Increases in Hospital Expenses: 1976-1978: A Comparison of States with Mandatory Cost Containment Programs and States Without Mandatory Cost Containment Programs," Washington, D.C., National Conference of State Legislatures. See also, Biles Brian, et al., "Hospital Cost Inflation Under State Rate Setting Programs," New England Journal of Medicine, No. 303, September 18, 1980, pp. 664-668.

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[28] *Ibid.*

[29] Commerce Clearinghouse, Medicare and Medicaid Guide, ¶14725, p. 6399.7

[30] State Plan Under Title XIX of the Social Security Act, State of Idaho, Methods for Payment of Reasonable Costs—Inpatient Hospital Services, Attachment 4.19A, draft.

[31] State Plan Under Title XIX of the Social Security Act, State of Michigan, Methods for Payment of Reasonable Costs—Inpatient Hospital Services, Attachment 4.19A, January 1, 1980.

[32] New York Office of Health Systems Management, "1980 Hospital Reimbursement Methodology," Albany, New York, 1980.

[33] For a detailed description of these systems see: A Prospective Reimbursement System Based on Patient Case Mix in New Jersey Hospitals, 1976-1981, Health Care Financing Grants and Reports, DHEW publication No: (HCFA) 03009-9-79; A Prudent Buyer Prospective Reimbursement System for Georgia Hospitals Annual Report 1977-1978, Georgia Department of Medical Assistance, Atlanta, Georgia, 1979.

[34] Russ Hereford, "Hospital Case Mix Reimbursement: The New Jersey Diagnostic Related Groups Experiment," Health Care Cost Containment Project, National Conference of State Legislatures, Denver, Colorado, September 1980; James Bentley and Peter Butler, "Case Mix Reimbursement Measures, Applications, Experiments," Hospital Finance Management, Vol. 34, No. 3, March 1980.

[35] *Ibid.*

[36] Robert Derzon and Connie Celum, The Medicaid Program: Strategies for Constraining Costs in the Largest Single Expenditure in the State Budget, San Francisco, California, Health Policy Program, University of California, December 1979, p. 64.

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[45] *Ibid.*

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[49] J. Feder, J. Holahan and T. Marmor (eds.), Conflicting Goal and Policy Choices, Washington, D.C., The Urban Institute, 1980, p. 115.

[50] Interview, Ira Burney, Office of Research, Demonstration and Statistics, Health Care Financing Administration, Department of Health and Human Services.

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[1] Bruce Stuart, "Utilization Controls" in Vol. 3 of Medicaid Cost Containment Series: Controlling Utilization Patterns, Washington, D.C., The Urban Institute, June 1977, p. 29.

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[3] Section 1902 (a)(30) of the Social Security Act, 42 CFR § 456.4(a)(2).

[4] Social Security Amendments of 1972, 42 CFR § 463.27(c)(1).

[5] Clark Havighurst and James Blumstein have aptly noted in their article "Coping with Quality/Cost Trade-Offs in Medical Care: The Role of the PSROs," Northwestern University Law Review, Vol. 7, No. 1, 1975, p. 9, that "although originally conceived by Congress primarily as a cost control device, physician dominated PSROs as now structured will systematically exaggerate the value of expensive, high-quality care. As a result, they are likely to perpetuate, if not exacerbate, the allocative biases which already characterize the health system." Those biases can be altered somewhat with state surveillance.

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[8] Statement of Richard Berman, Director, New York State Office of Health Systems Management, in the hearings before the Subcommittee on Health, Review of Professional Standards Review Program, p. 305. HEW can only remove the local PSRO authority after that evidence has been reviewed by a 3-member panel under the auspices of the New York Statewide PSRO Council and that panel has agreed that the local PSRO should be removed. New York has recommended a 2-year project in which the State and the PSROs would each review approximately 100,000 Medicaid discharges per year in 53 hospitals. NOTE: A state may impose utilization controls in those areas not reviewed by the PSRO and certain state duplication of effort is permitted before a PSRO becomes fully operational.

[9] *Ibid,* pp. 304-307.

[10] Bruce Stuart, pp. 30-31.

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[12] Interview with Jay Constantine, former Professional Staff Member, Senate Finance Committee.

[13] Interview, Vern Smith, Medical Services Administration, Michigan Department of Social Services.

[14] Emmet Grief, "Texas Medicaid Patient Profiling," in Conference Report: Medicaid and the Health Care Provider—a Partnership, December 12-15, 1977, Medicare/Medicaid Management Institute, HCFA, DHEW, pp. 65-80.

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[16] Grief, pp. 65-80.

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[28] The Containment of Medicaid Costs: A Report to the 1978 Legislature by the Minnesota Department of Public Welfare, p. F-4, F-5.

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[11] Joanne Finley, 268.

[12] "1979 Report of the Administrator: Health Services Administration," Public Health Service, Department of Health and Human Resources, DHHS Pub. No. HSA 80-7005, Rockville, Maryland, 1980, pp. 5-6.

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Chapter V

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[2] Urban System Research and Engineering, Inc., "Comprehensive Review of Medicaid Eligibility," Journal for Medicaid Management, Vol. 1, No. 3, Fall 1977, p. 33.

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[4] Beth Holmstrup and Thelma Johnson, p. 23.

[5] *Ibid,* p. 14.

[6] *Ibid,* p. 15.

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[8] Systems Architects notes three cases where error-prone profiling has been very effective.

1. "South Carolina scores every case according to error-proneness and reviews cases in order of priority from highest to lowest. A score is then calculated by the computer for each case... The score tells which cases should be reviewed first, specifying careful review for the error-prone cases and only a cursory review for cases with a low probability of error.

2. "West Virginia classifies the caseload into several homogeneous groups and specifies the case actions to be taken for each group. Case traits that have been shown in the error analysis to be indicative of a specific type of error (e.g., nonpayment, under-payment) are used to divide the caseload into several groups, each of which is given a specific corrective action.

3. "New Hampshire, on an experimental basis, sought to identify the single most error-prone group meeting

a minimum percent of the caseload. A Matrix of case characteristics that correlate to given error rates in the caseload are determined by statistical evaluation of case traits. The computer then splits caseload into two groups, an error-prone group with a specified minimum error rate or a representative of some specified minimum percent of the caseload, and a nonerror-prone group. The error-prone group is subject to an intensive review."

[9] *Ibid,* pp. 10-11.

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Chapter VI

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[4] 42 CFR 450.31.

[5] Beth Wahtera, p. 37.

[6] Frank Traglia, "Probate," Third Party Liability Workshop Papers, Washington, D.C., Institute for Medicaid Management, HCFA, DHEW, 1979, pp. 174-190.

[7] Rigby Leighton, p. 64; Robert Derzon and Annie Cellum, pp. 59 and 60.

[8] The Containment of Medical Costs: A report to the 1978 Legislature by the Minnesota Department of Welfare, p. F-7

[9] "A Bill for an Act Concerning a State Health Insurance Program," HB 1226, 52nd General Assembly, Second Regular Session, State of Colorado; See also "Features of the Colorado Health Care Cost Protection Act," February 4, 1980 (mimeo), and "Questions and Answers Concerning HB 1226, Colorado Health Care Protection Act," February 11, 1980 (mimeo).

[10] John van Steenwyk, Evaluation of Impact of Hawaii's Mandatory Health Insurance Law, Final Report, Federal Contract No. 299-77-0014, HCFA, DHEW, Region IX, November 30, 1978.

[11] Senate Bill 484, Oregon State Senate.

[12] House Bill 173, Idaho House of Representatives.

[13] Assembly Bill 217, Wisconsin General Assembly.

[14] PL96-611, §5(a), 94 Stat. 3567.

[15] David Smith, "An Impact Assessment of Mandatory Medicare Participation for Medicaid Certified Skilled Nursing Homes in Pennsylvania," 1980.

[16] Agreement between State of Washington Department of Social and Health Services and Western Optical, Contract No: 2028-ALR-26568, May 23, 1980.

Chapter VII

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[1] Ruth Roemer and William Shenick, "Private Management of California County Hospitals," paper presented at the American Public Health Association Annual Meeting, Detroit, Michigan, October 1980; William Shenick, "Mergers of Public Health Departments with Public Hospitals in Urban Areas," Supplement to Medical Care, Vol. 18, No. 8, August 1980, p. 2.

[2] "Project Health: Serving the Medically Indigent in Northwest Oregon," Urban Health, Vol. 9, No. 5, June 1980, pp. 30-39.

[3] *Ibid.*

[4] "Project Health: Ten Basic Principles," distributed during the presentation by Chris Neilsen at the National Conference of State Legislatures' and Intergovernmental Health Policy Project's Conference on Options for Controlling Medicaid Costs, Boulder, Colorado, March 1981.

[5] For a summary of those studies, see Rigby Leighton, "Excerpt from JBI Proposal to Evaluate Project Health Medically Needy Demonstration," Santa Rose, California, Jurgovan and Blair, Inc., April 3, 1981.

[6] Beverlee Myers, p. 92.

[7] Bruce Spitz and Jane Weeks, Medicaid Nursing Home Reimbursement in Minnesota, Washington, D.C., The Urban Institute Press, 1981.

[8] Unpublished study by the General Accounting Office, 1981.

[9] Ohio Administrative Code, Sec. 5101:3-1-56 (A)(8)(9), July 1, 1980.

[10] Interview, Gordon Bonnyman, Legal Aid, Nashville, Tennessee.

[11] Beverlee Myers, p. 91.

[12] Richard Posner, "Taxation by Regulation," The Bell Journal of Economic and Management Sciences, Vol. 2, No. 1 (1971), pp. 22-23.

Conclusion

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[1] Massachusetts Department of Public Welfare, Waiver Request, Fixed Budget Medicaid Program, April 1981.

[2] Beverlee Myers; also William Shenick, "Public Medical Care Networks: Some Thoughts on the Post-Proposition 13 Restructuring of Publicly Provided Health Services in California," presented to the California Health Department Advisory Panel on Alternative Future Configurations of the Public Health System, November 17, 1978.

[3] The voucher approach in Oregon was to be an extention of the Project Health arrangement to the medically needy in the state. It never became a formal proposal because of state budgetary problems. Interview, Becky Belangy, Multnomah County, Oregon.

[4] Interview, Cris Conover, Office of Policy and Budget, Kentucky Department of Human Resources, July 14, 1980.

APPENDIX A

Medicaid Provisions of the Omnibus Budget Reconciliation Act of 1981

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A. FEDERAL FINANCIAL PARTICIPATION

The 9 percent cap and the reduction in the federal matching floor to 40 percent that were included in the Senate bill were dropped in conference. The conferees instead agreed to temporary reductions in federal funding of 3 percent in FY 82; 4 percent in FY 83; and 4½ percent in FY 84. These reductions would be lowered by 1 percent for each of the following:

- state unemployment rates of at least 150 percent of the national average;
- state hospital rate review programs that *currently exist* and that meet criteria in the bill; and
- a documented 1 percent reduction in expenditures due to: in FY 82 only, recoveries through third party payment collection and through fraud and abuse control; in FYs 83 and 84, through fraud and abuse control only.

After adjusting the maximum federal funds reduction (3, 4 or 4½ percent) for the three factors just described, the remaining reductions in federal funds would be further offset if the rate of increase in program expenditures is within federal expenditure targets established for each State for the federal fiscal years 1982, 1983 and 1984. The FY 82 target for each State would be determined by multiplying by 1.09 the FY 81 state expenditures estimates submitted to the Secretary in February of 1981. The target would be increased in FYs 83 and 84 by the medical care expenditure component of the Consumer Price Index. Those States that contain expenditures to levels under the performance standard would be allowed to apply each dollar of federal "savings" against the reduction in federal funds that has occurred, and will receive a refund of those funds in the first quarter of the following fiscal year.

Example 1: In FY 82, a State that does not qualify for any of the three 1 percent offsets listed above would receive a 3 percent reduction in federal funds in FY 82. If a State's actual FY 82 expenditures are 9 percent or more over its February 81 estimate of FY 81 expenditures, it will receive no refund of the 3 percent reduction. If a State contains cost increases to 7.9 percent, the federal government would refund 1 percent of FY 82 federal funds in the first quarter of FY 83; if a State holds cost increases to 6.9 percent, it would receive a refund of 2 percent of FY 82 federal funds; if a State holds cost increases to 5.8 percent or less, it would receive a refund of the full 3 percent reduction.

Example 2: A State that has a qualified hospital rate-setting program and achieves a 1 percent reduction in expenditures due to fraud and abuse recoveries would reduce the maximum 3 percent FY 82 reduction by 2 percent, and receive a 1 percent reduction in federal funds in FY 82. If that State had FY 82 expenditure increases of 9 percent or more over its FY 81 expenditure estimates, it would receive no refund of the 1 percent reduction. If it has FY 82 expenditure increases of 7.9 percent or less, it would receive a refund of the 1 percent reduction in the first quarter of FY 83. If it has FY 82 expenditure increases of 8.5 percent, it would receive a 0.5 percent refund.

If federal regulations implementing changes in Title XIX regarding hospital reimbursement, services for the medically needy, and nursing home reimbursement are not promulgated by the first day of any quarter, States will not receive any federal funds reductions for that quarter. The federal funds reduction provisions are repealed effective October 1, 1984.

B. DISALLOWED FUNDS

States will continue to have the option to retain funds that are disallowed by the federal government when a state appeals the disallowance decision. However, the current

6-month limitation on state interest liability for appealed disallowances will be dropped. States that lose their appeal will be now interest-liable for the full period they retain disallowed funds.

C. STUDY OF THE FEDERAL MEDICAID MATCHING FORMULA

The conference agreement requires a study by the Comptroller General (in consultation with the Advisory Commission on Intergovernmental Relations) of the Medicaid matching formula and of possible adjustments in Medicaid expenditure targets for economic and demographic changes beyond a State's control. The report will study possible revisions in the formula, and is to be submitted to the Congress by October 1, 1982.

D. HOSPITAL REIMBURSEMENT

Current Law

States must reimburse hospitals on the basis of whatever costs are actually incurred by hospitals, as defined by Medicare "reasonable cost" principles, unless the Secretary has approved an alternative method.

Conference Agreement

Current provisions are replaced with a new requirement that States, using their own methods and standards, make payments that: 1) are "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities;" 2) are sufficient to assure that Medicaid patients have reasonable access to services of adequate quality; and 3) take into account the circumstances of hospitals which serve a disproportionate number of low-income patients with special needs. States must provide assurances to the Secretary regarding the filing of cost reports by each hospital and periodic audits by the State. The Secretary is required to develop a model prospective payment methodology for inpatient hospital services which could be used by the Medicare and Medicaid programs.

E. FREEDOM OF CHOICE/PRUDENT PURCHASE ARRANGEMENTS/ RELATED WAIVER AUTHORITY

Current Law

Medicaid recipients are free to choose any provider regardless of cost; States must provide each recipient with service coverage that is equal in amount, duration and scope to other recipients; a Medicaid program must be uniform statewide; the Secretary can waive federal requirements only to allow a State to conduct an experimental, pilot or demonstration project.

Conference Agreement

States are authorized to:

- purchase laboratory services and medical devices through competitive bidding arrangements if the Secretary finds that adequate services will be available, and that laboratories meet certain federal requirements;
- limit or suspend the participation of a provider that the State finds, after notice and an opportunity for a hearing: 1) has provided more services than medically necessary (as determined by state-by-state utilization guidelines), or 2) has provided services that do not meet professionally recognized standards of health care;
- restrict to particular providers individuals that the State, after notice and opportunity for a hearing, finds overutilize services (many States already "lock in" recipients who overutilize services); and
- contract with an organization providing broader service coverage than those generally offered under the state plan, so long as recipients are free to choose whether to

obtain care from the organization.

The Secretary is given waiver authority to allow States to:

- restrict providers from or through whom a recipient can obtain services (other than emergency services) so long as: 1) the providers comply with reimbursement, quality and utilization standards under the state plan; 2) the restrictions are consistent with access, quality, and efficient and economic provision of care and services; and 3) the restrictions do not discriminate among classes of providers on grounds unrelated to their demonstrated effectiveness and efficiency;
- implement a case management system or specialty physician services arrangement which restricts the provider through whom recipients can obtain primary care services;
- share savings of cost-effective medical care with recipients through expanded service coverage; and
- allow localities to act as central brokers in assisting recipients in selecting among competing health care plans.

F. SERVICE FOR AND COVERAGE OF THE MEDICALLY NEEDY

Current Law

States choosing the option to cover the medically needy must:

- cover all medically needy categories (e.g., aged, blind, disabled, and families with dependent children);
- offer all categories of recipients services that are comparable in amount, duration and scope; and
- offer a minimum number of services, and a mix of institutional and noninstitutional services.

Conference Agreement

Current requirements are repealed, substituting new provisions which require that:

- if a State has a medically needy program, it must provide ambulatory services to children and prenatal and delivery services for pregnant women;
- if a State covers institutional services for any medically needy group, ambulatory services must also be covered for this group; and
- if a State medically needy program covers persons in intermediate care facilities for the mentally retarded, it must meet current law service requirements for all groups covered by its medically needy program.

G. HOME AND COMMUNITY-BASED NONMEDICAL LONG-TERM CARE SERVICES

Current Law

Federal Medicaid funds are generally not available for nonmedical long-term care services outside of an institution, while comparable services are covered in an institution when a physician certifies that intermediate or skilled nursing care is medically necessary.

Conference Agreement

The Secretary is authorized to waive federal requirements to enable a State to cover home or community-based services (other than room and board) for individuals that the State determines would otherwise need institutional care. The Secretary may not grant such a waiver unless the State provides assurances that:

- the average per capita Medicaid expenditure estimated by the State for individuals receiving care under the waiver does not exceed the per capita expenditure that the

State estimates would have been made for such individuals if the waiver had not been granted (i.e., if the individual had been institutionalized);

- the State will provide an evaluation of need for recipients eligible for skilled or intermediate nursing facility services);
- the State will inform individuals who are determined likely to need skilled or intermediate level nursing care of the feasible alternatives that are available, at the individual's choice, under the waiver;
- necessary safeguards, including adequate provider standards, have been taken to protect the health and welfare of recipients and to assure financial accountability; and
- the State will provide to the Secretary annual information regarding the impact of the waiver on the type and amount of services provided and on the health and welfare of recipients.

Under the waiver authority, a State may cover additional services, pursuant to written plans of care for recipients. Services include homemaker/home health aide services and personal care services, adult day care, habilitation services, respite care, and other services requested by the State and approved by the Secretary.

The Secretary may grant a three-year waiver of the "statewideness" requirement, which must be extended for an additional three years at the request of a State unless the Secretary determines that, for the initial three-year period, the State has not met the required state assurances the State provided to the Secretary, as listed above. (This will allow a State to implement and refine new services and program structures in some, rather than all, areas of the State.) States may also set limits on the amount, duration and scope of services provided to individuals under the waiver which vary from what is available to other recipients. The required written plan of care will delineate the number and frequency of services to be provided to an individual served under the waiver, and the State may establish a per capita ceiling on the total cost of each client's care.

States may also limit eligibility for services under a waiver to individuals who the State expects will use no more services than the "amount of medical assistance provided for such individuals if the waiver did not apply."

H. COVERAGE OF INDIVIDUALS AGE 18-20

Current Law

States that cover students age 18-20 in their AFDC programs must provide Medicaid coverage to all persons under 21 who would be eligible for AFDC if a student; state Medicaid programs that cover certain non-AFDC low income children must cover all, or reasonable categories of, such children under age 21.

Conference Agreement

States may limit coverage to children under 21, 20, 19, or 18, or any reasonable category of such children.

I. TIME LIMITATION FOR FEDERAL APPROVAL OF PROPOSED CHANGES AND WAIVER REQUESTS

Current Law

There is no time limit on Secretarial action on state waiver requests.

Conference Agreement

State requests for waiver and for approval of state plan changes shall be deemed granted unless within 90 days the Secretary either denies the request in writing or requests

additional information. If additional information is requested, the waiver shall be deemed granted unless the Secretary denies the request within 90 days of receiving such additional information.

J. HMO AND RISK-SHARING ARRANGEMENTS

Current Law

States may enter into prepaid capitation or other risk-based reimbursement arrangements only with entities meeting federal HMO standards, with certain exceptions. Within three years of contracting with Medicaid, an HMO must have an enrollment consisting of less than 50 percent Medicaid and Medicare beneficiaries. Federal matching funds are not available for recipients who enroll in an HMO while Medicaid eligible and subsequently lose their eligibility. (Frequent changes in Medicaid eligibility status have been a major cause of reluctance on the part of HMOs to participate in the program.)

Conference Agreement

States may enter into prepaid arrangements with other entities than federally-qualified HMOs, provided that:

- the entity makes covered services available and accessible to Medicaid recipients to the same extent as they are to other Medicaid eligibles in the area; and
- adequate provisions are made by the entity against the risk of insolvency, and in no case can enrollees be liable for debts of the organization.

The 50-percent ceiling on Medicaid and Medicare beneficiary enrollment is raised to 75 percent; the Secretary may waive the ceiling entirely for public HMOs.

States may establish minimum enrollment periods of up to six months for Medicaid beneficiaries enrolled in federally-qualified HMOs, and federal matching payments would be available for that full period even if general Medicaid eligibility is lost.

The Secretary is given waiver authority to allow States to share with clients the savings from cost-effective health care delivery methods through the provision of additional services.

The Secretary is required to conduct a study evaluating the extent of, and reasons for, the termination of HMO enrollment by Medicaid recipients.

K. REPEAL OF EPSDT PENALTY

Current Law

States are subject to a penalty of 1 percent of federal AFDC matching payments if they fail to meet certain federal requirements for the Early and Periodic Screening, Diagnosis and Treatment program.

Conference Agreement

The penalty provisions are repealed retroactive to June 30, 1974. Effective October 1, 1981, EPSDT requirements are incorporated into normal state plan requirements.

L. ELIMINATION OF MANDATORY PSRO PURVIEW OVER MEDICAID

Current Law

States are mandated to give PSROs purview over Medicaid utilization review activities. The Secretary contracts with PSROs to conduct Medicare and Medicaid reviews to determine whether services are medically necessary, provided in accordance with professional standards, and rendered in an appropriate setting. The federal government finances 100 percent of the cost.

Conference Agreement

States are given the option of contracting with PSROs for Medicaid review, and would receive a 75 percent federal match for the costs of PSRO review. States would, of course, employ other utilization review mechanisms and receive the normal 75 percent Medicaid match for medical personnel.

M. REIMBURSEMENT FOR INAPPROPRIATELY PLACED PATIENTS

Current Law

Present law, as amended by last year's reconciliation bill, requires that, for hospital patients who are only in need of nursing home care, Medicare and Medicaid will reimburse hospitals with occupancy rates of 80 percent or more at hospital rates for such patients, rather than at nursing home rates as for other hospitals.

Conference Agreement

The 80-percent occupancy test is eliminated, but in cases where the Secretary determines there is no excess of hospital beds, hospitals will be reimbursed at the hospital rate. In the case of public hospitals, the determination of whether or not there is an excess of hospital beds shall be based on only public hospitals in the area under common ownership.

N. OTHER PROVISIONS

Requirements that state payments for physicians' services and certain medical supplies and laboratory services are within reasonable charge levels established by Medicare are repealed.

States are allowed to forego third-party recoveries if the cost of recovery can be reasonably expected to exceed the amount to be recovered.

States may use physician assistants or nurse practitioners (rather than only physicians) to conduct mandated 60-day certification of need for Medicaid recipients in SNFs and ICFs.

Federal matching payments are prohibited, except in emergencies, for inpatient hospitals tests, that are not specifially ordered by the attending physician.

Federal payments are prohibited for drugs that the Secretary, or his delegate, determines to be less than effective in use.

The Secretary is authorized to impose a civil money penalty of up to $2,000 per item and an assessment of up to twice the amount of claims determined to be fraudulent, and to bar from participation in Medicare and Medicaid personss submitting such claims. However, no penalties will be assessed nor payment prohibited until all administrative remedies have been exhausted.

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The Intergovernmental Health Policy Project serves a unique function in the development of the nation's health policy. It is the only university-based program in the country concentrating its research efforts exclusively on the health laws and programs of the 50 States. The Project provides assistance to state executive officials, legislators, legislative staff and others who need to know about important developments in other States. At the same time, the IHPP helps federal officials identify innovative state health programs and specific state problems.

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